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SURGICAL TREATMENT OF PULMONARY TUBERCULOSIS*

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SURGICAL treatment of pulmonary tuberculosis marks an important advance in the control of this disease. Collapse therapy or surgical treatment has revolutionized our attitude toward the disease which was considered not so long ago as hopeless. In the words of Riviere of London, "No more hopeful ray of sunshine has ever come to illumine the dark kingdoms of disease than that introduced into the path of the consumptive through the discovery of artificial pneumothorax."

Historical. Carson, in England, advocated the use of artificial pneumothorax on theoretical grounds in 1821. Houghton, in the same country, reported in 1832 a case of far-advanced tuberculosis, in which a spontaneous pneumothorax took place, and was followed by recovery to the extent that the patient returned subsequently to his occupation, that of bricklaying.

Artificial pneumothorax was first practiced clinically by Potain of France in 1882. He treated a case of spontaneous hydropneumothorax by aspirating the fluid and replacing it with atmospheric air. During the same time, and working independently, Forlanini of Italy was carrying on extensive research in the principles of artificial pneumothorax. He did not publish his epoch-making observations until 1895-1896.

Pneumothorax was first practiced in America by the surgeon John B. Murphy of Chicago, who urged its use, and practiced it on grounds of surgical principles in 1898. His pupil, Lemke, reported on fifty-three cases in 1901. Brauer of Germany was the next man to practice it, and reported his work in 1905-1906. Artificial pneumothorax thereafter spread to all countries of Europe, with Forlanini and his pupils as the leading school. A few years later interest in its application was revived in America by three Boston physicians, Balboni, Robinson, and Floyd in 1912. Some of the workers who have advanced the use of this mode of therapy in America are Sewall, Webb, Peters, the Matsons and a host of others.

In order to follow the rationale of collapse therapy, it is necessary to bear in mind the evolution of the disease. Once the lung is infiltrated with tuberculosis, several events can take place: the infiltrate may undergo complete resolution, leaving in its wake the obsolete or primary tubercle. This phenomenon represents the most desirable effect. More commonly, however, an evolution of the infiltrate occurs with the production of fibrosis, calcification or both. This, too, is a favorable aspect of the disease. The third phase, and one we are principally concerned with, is the infiltrate which undergoes caseation, necrosis, and produces cavities.

The last phase is the most serious, in which a spontaneous cure is not expected to take place by employing medical means alone, even after prolonged periods of bed-rest treatment. This is so because the disease is confined to an organ in a state of constant expansion and contraction. In the use of collapse therapy we have a means at hand to place the constantly moving lung at rest.

Artificial pneumothorax. The epoch-making announcement of Forlanini in 1895, that physiologic rest of the lung is essential in healing tuberculosis, marks the transition from empirical to rational therapeutics in this disease. Artificial pneumothorax is the forerunner of other surgical measures for treating tuberculosis, and is practiced before undertaking more radical means.

When a pneumothorax is induced several phenomena take place: Diseased tissues are placed at rest. Cavities are closed, thus helping to eliminate a source of danger, since the cavity acts as a reservoir for bacilli, and favors spread of the disease to unaffected parts of the lung or lungs. Necrotic tissue is collapsed thus giving support to blood vessels contained therein, which in turn lessens the likelihood of hemorrhage. The lymph flow is impeded, thereby inhibiting toxic absorption. A compression atelectasis of the lung is produced which favors fibrous tissue proliferation, an important element in tuberculosis healing.

The indications for the production of a pneumothorax are as follows: (1.) Lesions which do not respond to a suitable period of intensive bed-rest treatment. (2.) Lesions which have gone on to the stage of caseation in spite of bed-rest. (3.) The presence of cavities. (4.) The occurrence of hemoptysis. Concerning hemorrhage, it may be said that while the patient views it with a great deal of alarm, the physician is apt

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to regard it in the light of conservative optimism. To be sure, a hemorrhage tends to stop spontaneously in many instances, but this is not a logical reason for expectant treatment, because a marked loss of blood tends to lower resistance against the disease. Furthermore, hemorrhage is apt to be recurrent. Again, every bout of blood-spitting offers a dangerous opportunity for the migration of tubercle bacilli into healthy lung tissue. The most practical means of controlling hemorrhage is by the application of mechanical agents, and is readily accomplished by the use of lung compression which is effected by an induced pneumothorax.

There is a period in the evolution of the disease when the application of the Forlanini principle of therapy is ideal. It is the stage at which caseation becomes manifest in the presence of clinical activity. To induce a pneumothorax at this time is to treat the disease in its early rather than in its late manifestations,—it is to treat an acute rather than a chronic process. In the acute or subacute stage, the lung is readily compressed, the period of treatment is shorter, complications are less common and closure of cavities is comparatively easy. In contrast, the chronic case presenting a rigid, fibrotic lung, is more difficult to treat. Pleural adhesions are apt to be present not only in great numbers, but are usually of the variety which precludes inflation of the pleural sac, and in turn lung compression. Moreover, cavities found in the chronic type of tuberculosis are characterized by rigid walls, which render their closure difficult if not impossible. Pleural adhesions are the most common obstacle to effective pneumothorax therapy.

When pneumothorax is elected for the patient, the question raised is: "What is the condition of the other lung?" The question is an important one, since immobilization of one lung places an added physiological burden upon the contralateral lung. As a matter of interest, now purely historical, Forlanini considered unilateral disease a requisite for the induction of a pneumothorax. The latter view unfortunately still prevails in some quarters. Extensive experience with induced pneumothorax, especially during the past decade, has brought about a change in viewpoint on that score, and points to the following observations: Inactive lesions in the contralateral lung are well able to carry added function. Moreover, lesions in the better lung at times improve, and even clear up entirely with the induction of a pneumothorax on the worse side. Certainly, unilateral tuberculosis is uncommon, especially when the disease has been manifest for some time.

The effects of an induced pneumothorax are striking. Fever tends to subside, eventually disappearing entirely. Cough and expectoration, especially troublesome in the presence of cavities, are abated, permitting rest and quiet sleep. By lessening of toxemia, the appetite and digestion are improved, thus favoring gain in strength and flesh. Pain, due to recurring pleural inflammation, is eliminated as a result of the separation of the pleural surfaces by the created pneumothorax. The case presenting no mechanical obstacles to compression shows an immediate clinical improvement, and, if artificial pneumothorax is continued over a sufficient period, it will tend to arrest the disease.

To carry the development of collapse therapy further, we may consider those cases in which the presence of adhesions permits only a partial lung collapse. It was the practice not so very long ago to stretch pleural adhesions by inflating the pleural sac under considerable pressure. This is a dangerous practice, well known to artificial pneumothorax operators, and is unsound for two reasons. (1.) It invites perforation of the lung; and (2.) the futile effort at stretching adhesions entails a loss of time, since the patient is deprived in the meantime of less dangerous, as well as more effective measures of lung collapse.

To overcome the obstacle of adhesions preventing lung compression, Jacobaeus of Stockholm devised an operation whereby these adhesions are severed at their parietal pleural attachment. This is accomplished by the use of an electrocautery, the pleural cavity having been previously illuminated by the pleuroscope. When visualized and isolated and found suitable for treatment the adhesions are burnt. Following this procedure the adhesions retract, permitting the air already present in the pleural cavity to compress the lung more effectively. In consequence closure of cavities is enhanced considerably. Jacobaeus first described the operation in 1913, and it has since borne the name of intrapleural pneumolysis. The operation is an indispensable adjunct to artificial pneumothorax.

Before discussing technique, indications, and contraindications for pleural pneumolysis, a brief consideration of the pathologic anatomy of pleural adhesions is in order. Following attacks of pleuritis, with accompanying pleural exudate, a number of adhesions develop between the pleural layers. These adhesions are bands of fibrous tissue extending between the visceral and parietal layers of the pleural sac.

There are various types of pleural adhesions. One variety consists of thin, single bands easy to handle. A second variety consists of broad, usually multiple pleural bands, generally containing blood vessels of varying size, and is more difficult to treat. A third type of adhesion, and most difficult to manage, is the kind containing projections of lung tissue which frequently contain elements of tuberculous caseation with cavities.

The first type of adhesion is managed easily by the use of the Jacobaeus technique employing the electrocautery. Management of the second type of adhesion has been enhanced by the recent development of the diathermic technique.

The third variety, because difficult and dangerous to approach by pneumolysis, is usually managed by other measures of lung collapse.

Phrenicotomy. Interruption of the phrenic nerve is another chapter in the evolution of surgical treatment for tuberculosis. The phrenic nerves have their origin in the neck. They traverse the thoracic cavity, their terminal motor fibers entering the two leaves of the diaphragm. Function of the diaphragm depends upon uninterrupted function of these nerves.

The operation of phrenicotomy was devised by Stuertz in 1911. He proposed its application in the management of cases of tuberculosis confined to the base of the lung. The objective of this operation was to interrupt innervation to the diaphragm; the expected result was the production of a hemidiaphragmatic paralysis, whereby the ascending diaphragm would move upward, and exert a compression effect upon the lung. It was soon observed, however, that the diaphragm tended to resume function shortly following simple section of the nerve. Later on, phrenicectomy was adopted, whereby a segment of the nerve was removed.

It was finally demonstrated by Felix in 1921 that lack of universal success with simple section, or resection of a segment, was due to the common presence of accessory phrenic nerves which join the main trunk below the level of operation. Felix introduced the operation which he called phrenic exeresis, which is an evulsion of the nerve trunk with all its branches. By the upward movement of the diaphragm a compression of the lung is generally effected, reducing its volume by fifteen to thirty per cent. Hence, lung movements are correspondingly lessened.

In recent years, with better understanding of the mechanism of lung collapse, the operation has been extended in its scope of application. Basal lesions, nevertheless, are still ideal for this operative procedure. The operation is useful in treating upper as well as basal lesions. It is used to supplant a previously unsuccessful attempt at artificial pneumothorax, where massive adhesions prevent its induction. It is of distinct value to improve the effects of an established pneumothorax in which diaphragmatic adhesions prevent closure of cavities in the lower and middle portions of the lung. Diaphragmatic ascent in the latter type of case permits shortening of the adhesions, which in turn permits relaxation of the lung. The mechanism just described favors lung compression in general, and cavity closure in particular. Phrenic nerve exeresis is likewise indicated in an established pneumothorax in which lung rigidity resulting from chronic disease retards relaxation of diseased tissues by the use of pneumothorax alone. A phrenic exeresis is performed in those cases of established pneumothorax in which the lung shows the tendency for spontaneous reëxpansion because of rapidity of air absorption from the pleural sac. The ensuing diaphragmatic paralysis slows up air absorption to a great extent.

Thoracoplasty. The popularity of plastic operations on the thorax preceded by many years the subsequent acceptance of artificial pneumothorax. Plastic operations on the thorax had their inception in the work of de Cerenville of Lausanne, who in 1885 resected ribs with the view of collapsing cavities. In 1890 Spengler extended the scope of the operation, and introduced the term "extra-pleural thoracoplasty",—the word "thoracoplasty" being borrowed from Estlander, who had used it for his operation for the cure of chronic empyema.

Subsequent years saw thoracoplasty undergo modifications in technique while the scope of its application has been widened. In the meantime, artificial pneumothorax was gaining ground. The clear relationship between the aims and results of these two operations alone remained to be recognized, and to Brauer goes the credit for so doing. In 1907, confronted by a case where extensive pleural adhesions prevented the induction of a pneumothorax, Brauer persuaded his surgical colleague, Friedrich, to collapse the lung by an extensive rib resection. The patient, whose disease was considered incurable, made a good recovery, and was reported by Brauer well in 1922.

Thoracoplasty has undergone numerous modifications in technique. In recent years the accepted operation has been the paravertebral thoracoplasty of Sauerbruch, who is the pioneer in the modern application of the principles of thoracoplasty. In this operation portions of the first ten or eleven ribs are removed in the paravertebral region.

The aims of a thoracoplasty are complete immobilization of the bony hemithorax, and release of the lung from its condition of expansion. Removal of portions of rib reduces the girth, and when this includes resection of the first rib, as is always necessary, the whole hemithorax falls downward in a condition of extreme expiration and remains immobile. Aside from complete immobilization of the lung, effected by a well performed thoracoplasty, a diffuse proliferation of fibrous tissue takes place within the organ, and, in the opinion of Sauerbruch, fibrosis developed in the lung after thoracoplasty is even greater than that following artificial pneumothorax.

The indications for a thoracoplasty are very similar to those for pneumothorax save that they demand a stricter interpretation, and for obvious reasons: (1.) It is an operation requiring a patient able to withstand a major surgical procedure. (2.) The operation produces a sudden immobilization of the lung as contrasted with a gradually induced pneumothorax. (3.) Once done it cannot be undone.

The operation is selected for the type of disease which is chronic in nature and which shows a great deal of fibrosis in the presence of cavities. It is distinctly contraindicated in the exu-

dative type of tuberculosis, since sudden lung collapse in the latter type of disease favors extension of the process. It must be emphasized at this point that a poorly considered thoracoplasty, no matter how skilfully performed, can easily bring about disaster.

When a thoracoplasty is considered, careful study must be made of the condition of the contralateral lung. Disease per se in the better lung is no contraindication to the performance of a thoracoplasty on the worse side. In order to go ahead safely with the operation, the following questions must be answered in the affirmative: (1.) "Has the other lung a limited amount of disease?" (2.) "Is it free from recent activity?" (3.) "Does it show evidence of fibrosis?"

Though some continental surgeons perform the operation in one stage, the majority of operators on this continent do it in two or more stages. A preliminary exeresis of the phrenic nerve is considered by the majority of operators a practical procedure, though some surgeons do not see the need for so doing. In the opinion of Sauerbruch a preliminary exeresis of the nerve acts as a good test for the future behavior of the contralateral lung after thoracoplasty.

SUMMARY

Surgical treatment for lung tuberculosis has widened the horizon of therapy for this disease. It affords an opportunity for recovery to those patients whose natural forces are not sufficient to combat the disease. Surgical treatment should not be the initial therapy. It is not to be carried out as a last resort. Neither should it be employed as a short-cut in healing tuberculosis. As a surgical corollary to medical treatment, collapse therapy plays an integral rôle in the therapeutics of pulmonary tuberculosis.

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DISCUSSION

JACOB KAMINSKY, M.D.: There is little that I can add to the very excellent presentation of the subject of collapse therapy as given by the previous speakers, excepting that I would like to emphasize the importance of the palliative side of this form of treatment. I believe that the scope of collapse therapy will be greatly widened if due consideration is given to its palliative phase.

There is a wide variation in the percentage of patients treated by artificial pneumothorax in the various sanatoria. The percentages range from the high figures of 34 per cent attempted and 24 per cent actually treated, to the low figures of 2.5 per cent attempted and 1.5 per cent actually treated. A number of factors are probably at the basis of this rather wide divergence in the applicability of such a widely accepted form of treatment as artificial pneumothorax. But whatever the other causes may be, it would seem that, in a large measure, these differences are due to variations in the degree of emphasis placed on the palliative phase of collapse therapy. Certain operators limit their efforts to the so-called classic case for artificial pneumothorax. It is the case with severe one-sided disease and with the contralateral lung clear or nearly clear to physical examination. Their aim is to obtain an anatomical or at least a clinical cure. On the other hand, there are those who content themselves with the more modest objective—the relief of symptoms and prolongation of life. Pneumothorax operators will agree that much temporary improvement is often obtained in seemingly hopeless cases. Furthermore, even cures are not unknown to occur in instances where temporary improvement was the most that could be hoped for at the outset.

The question of palliative treatment arises when both lungs show considerable involvement. Autoinoculation from the more involved lung may then be reduced by partial compression of that lung. In certain instances both lungs are partially compressed with the same objective in mind. This may seem a rather heroic measure and probably brings to the minds of many the idea of suffocation. However, operators who had experience with bilateral pneumothorax will agree that anoxemia is practically unknown if the treatment is carried out cautiously and when overinsufflation is guarded against.

The surgical procedures of collapse therapy which have been developed in recent years, increased greatly the opportunities for palliative treatment in pulmonary tuberculosis. Definite improvement often results after a phrenicectomy or phrenicotomy in cases where artificial pneumothorax was impossible because of an adherent pleura and a thoracoplasty contraindicated because of involvement of the contralateral lung or because of a poor general condition. Bilateral upper thoracoplasty is a new surgical procedure which is just entering the field of collapse therapy, and we hopefully look to this surgical measure for relief for some of our many patients with bilateral tuberculosis.

It is estimated that about two-thirds of the patients who present themselves for treatment are beyond the favorable stage. Many of them are certainly beyond the stage where spontaneous healing of the lesion could be expected or where they could answer to the rigid requirements of a classic case for pneumothorax treatment or prove to be favorable cases for the major surgical operation of thoracoplasty. Palliative collapse therapy in one form or another, is the only hope in many of these instances.

DR. ANDREW PETERS, Middlesex County Sanatorium: I note that Dr. Joress includes artificial pneumothorax among the surgical measures for the treatment of pulmonary tuberculosis and probably it should be so included, although ordinarily performed by the phthisiologist, or tuberculosis specialist, rather than by the practitioner of major or thoracic surgery. The technique should at least approach that of ideal surgical asepsis, even though the risk of external contamination from slight breaks is not great. It is now pretty generally agreed that the not infrequently occurring pleural exudates which may complicate artificial pneumothorax are due mainly, if not entirely, to endogenous infection, as they present the usual characteristics of tuberculous exudates on the one hand, and, on the other, non-tuberculous animals given artificial pneumothorax do not seem to develop these pleural exudates. It is perhaps a digression to speak of pleural exudates, were it not for the fact that they are the most common complication of pneumothorax, artificial or otherwise, in tuberculosis. Their incidence has been variously estimated, but if one includes small symptomless exudates and follows and observes these patients long and carefully enough, it will reach 50 per cent or more, of which perhaps the great majority are of no serious clinical importance except that they may lead to attachments and symphysis which may eventually necessitate abandoning the pneumothorax, sometimes prematurely. It is especially in such cases that the question of supplementary surgical measures to maintain lung collapse arises.

To refer to the historical aspects of pneumothorax therapy, Potain's replacement of fluid by air belongs, perhaps, in another category than induced collapse of the lung. It suggests, however, a useful procedure in handling large pleural exudates. In such cases, if you remove too much fluid without such replacement, the patient frequently exhibits distressing, if not actually alarming, symptoms, due to sudden forced expansion of a previously massively atelectatic lung.

The original report of J. B. Murphy's associate, Lemke, in the *Journal of the American Medical Association* for October 14, 1899, makes interesting reading, especially the description of technique: "An ordinary spear-pointed aspirating needle is inserted in the fifth or sixth interspace about the anterior axillary line or posterior to it. Assure oneself that the point of the needle is in the pleural cavity by instructing the patient to take a series of deep inspirations, when a current of air can be heard to rush in. If in the lung, a little frothy blood will appear," and further, "eighty cubic inches is the minimum quantity which can be expected to collapse the lung. The immediate effect is to increase the pulse rate and dislocate the heart" . . . "There may be pallor and syncope . . . from 50 to 170 cubic inches of nitrogen are injected, all at one sitting." When one calculates that this represents well over 2000 cubic centimeters of gas, one is not surprised that some of the patients exhibited alarming symptoms. The original apparatus used by Lemke consisted of a cylinder of nitrogen gas, a pressure gauge, a container of the spirometer type, connections, and a needle. The manometer, a most essential feature today, was introduced later. In all, Lemke reported 53 cases, with at least temporarily good results in the majority. However, the period both of observation and treatment was very brief for such a disease as pulmonary tuberculosis. The same criticism may apply today to many of the case reports on bilateral pneumothorax and other measures. Apropos of the gas used for pneumothorax, it may be mentioned that nitrogen has been generally discarded in favor of air, which is always available, costs nothing, and is equally satisfactory, since it has been demonstrated by Rist and Strohl, and amply confirmed, that the gas in a closed pneumothorax soon attains a uniform composition, due to physicochemical laws and the permeability of the pleural lining.

In certain emergencies, principally sudden profuse hemoptysis, where the side of the bleeding can be determined, either by previous knowledge of the case, or, better, by direct auscultation, a somewhat crude but effective method of inducing pneumothorax may be used when the usual facilities are not available. Fishberg suggests the insertion of an ordinary Luer needle of sufficient size, listening for the sucking sound which should occur when it reaches free pleura. We prefer to attach to the needle a small syringe containing novocaine solution, if available, or if not, saline solution or even sterile water, and to watch for suction on the piston indicative of negative intrapleural pressure. The syringe is then removed and air allowed to enter with each inspiration.

Should one induce pneumothorax without a previous roentgenographic picture of the chest? Under most circumstances, no, but in such emergencies as just referred to, I believe to do so is not only fully justified but urgently indicated, just as immediate use of diphtheria antitoxin is sometimes imperative without waiting for the laboratory report. Furthermore, roentgenographic films during or immediately after severe hemoptyses are apt to be unsatisfactory, if not actually misleading, because of the shadows cast by blood on the bronchial tree and the reaction around such foreign material.

The general medical adviser is apt to want to know a number of things about therapeutic pneumothorax, if he is interested at all, among them these:

1. In what type of case is it most indicated or most effective?
2. What, if any, are the risks, disadvantages, etc.?

3. How long must it be continued and will the patient have to remain under institutional care?

All of these questions are entirely warranted and should be answered to the best of our ability, carefully and thoughtfully. The second question I have briefly touched on in mentioning pleuritic exudates. A few of these, we must admit, are serious, being associated with perforation of the lung and virulent infection. These most serious complications, however, usually occur in patients with the most severe and advanced disease, whose prognosis would ordinarily be most grave. Embarrassment of the circulation or of the opposite lung function should not occur under proper or careful administration. Cerebral air embolism is a rare accident, which a careful technique should practically banish. So-called "pleural shock" or "pleural eclampsia" is an unfortunate term which does not identify any real clinical picture or have any definite pathological basis, but too often beclouds the real nature of some untoward occurrence and conceals our ignorance.

To revert to the question of indications, there is undoubtedly a recent tendency to expand the indications and limitations of pneumothorax therapy considerably. One sometimes wonders if the pendulum has not swung a trifle too far and if this valuable method in well-selected cases is not too indiscriminately applied.

A progressive lesion in one lung is, of course, the primary indication for pneumothorax therapy, generally agreed on. But the length of time for observation to determine whether spontaneous retrogression or recovery is likely to occur without recourse to pneumothorax or other collapse measures is not uniformly agreed on, and many factors must be considered, such as the previous course, duration and type of the disease, especially the tendency to tissue destruction, as indicated by development of thin-walled cavities, disintegrating caseous areas, etc. The status of the opposite lung should be estimated and consideration given to that indefinable thing which is none the less real and important, the individual resistance. Age and type of disease appear to bear some relation, not invariable. The childhood type of tuberculosis, largely through the careful observations of Chadwick, Myers, C. H. Smith, etc., is now recognized as exhibiting different characteristics from the adult type, and an adolescent type is now being further separated from both. A middle-aged and a senile type have been distinguished, especially by certain English writers. We also pass into the realm of "constitutional types" or "panels", rescued by Draper, of New York, from the limbo of forgotten things and elevated to the plane of scientific discussion. The morphological-pathological classification of tuberculous lesions elaborated especially in Germany, while not absolute, is also of some use in the consideration of patients for pneumothorax or other measures.

All of this may seem to lead rather far afield, yet it enters into the final estimate or judgment concerning the selection of cases. As for the proportion of phthisical patients suited for trial of artificial pneumothorax, this must necessarily vary somewhat in different institutions according to the type of patient most commonly admitted and cared for. Institutions which can select especially the more early and favorable cases will probably run slightly below the average, as will also municipal hospitals or wards where the most long-standing and terminal cases congregate. It is surprising, however, what a considerable number of patients can be discovered who are likely to derive benefit from pneumothorax therapy if someone is sufficiently interested to find them and extricate them from the mass of patients seen.

Speaking both from personal experience and from data obtained by a committee of the American Sanatorium Association, which I personally helped to collect, I should estimate roughly that 20 per cent of patients in sanatoria where young adults preponderate should be given artificial pneumothorax. A few years ago this would have been deemed excessive by most phthisiologists, whereas today we have earnest and competent experts who would be inclined to double this proportion. I think they are over optimistic, and rather than dwell long on the type of case where the indications are outstanding, which has been already set forth by Dr. Joress, I should prefer to touch on some borderline types as I have encountered them.

Acute fulminating types of pulmonary tuberculosis, seen especially among very young adults or adolescents, occasionally yield brilliant immediate results when the involvement is wholly or predominantly unilateral and the general condition not too greatly impaired. The ultimate results in this type are too often disappointing, with sudden contralateral extensions, virulent pleurisies, or generalized disease writing "finis" to the picture.

At the other end of the scale, the extremely chronic fibroid types of disease, most common toward middle life, either with or without cavitation, rarely show any marked benefit from pneumothorax, tissues being stiff and fibrous, adhesions common and cavities difficult to collapse. Many of these, however, who would ordinarily drag out a more or less invalid existence, are suitable for thoracoplasty, if they meet its more strict requirements regarding the contralateral lung.

The pneumonic types of tuberculosis constitute a problem in connection with collapse therapy. Massive consolidations, as seen in young adults, are not generally speaking very responsive to pneumothorax treatment. The pneumonic tissues, being rigid, do not readily collapse, the patient's general resistance is apt to be low, and acute virulent pleural exudates are unusually common. Occasionally, however, especially

in the less acute types, unexpectedly good results occur, just often enough for us not to be entirely discouraged. In children the pneumonic or "exudative" forms of disease seem to be of different nature and carry a better prognosis. I refer to what the French term "epituberculosis." Armand Delille, among others in France, has used pneumothorax in this sort of lesion, as well as in the caseating type with positive sputum where he thinks it urgently indicated if predominantly unilateral.

One may say, in roughly summing up, that it is the tuberculous patient who is still in fair condition, whose disease is neither too acute nor too chronic, and who shows some indications of resistance although his disease tends to progress in one lung, with some tissue destruction, who should especially have artificial pneumothorax if possible. The ages of preference might be set, for females, between 18 and 40, or males, between 21 and 45. Adolescents with marked pulmonary involvement have been noted to respond poorly, even while seeming to be improving. Without more data it is difficult to say how much their outlook may be improved with pneumothorax, if at all.

Phrenic nerve extirpation, resection, or avulsion, being a more recent procedure is more, it seems to me, in a state of flux as to its accomplishments and indications. At present I should hesitate to hazard any definite guess as to what proportion of patients should have this done. I do not think very much of it as an aid to artificial pneumothorax, except in special cases. It is perhaps of more value when pneumothorax is impossible or abandoned. Because it is so easy to do, it is also easy to overdo.

Thoracoplasty, in one form or another, is our final big gun and can wreak havoc if misfired. Its associated risks are well known to both phthisiologist and thoracic surgeon and have been greatly reduced in recent years. Even so it is a procedure applicable to a much smaller group than pneumothorax therapy, perhaps 3 to 5 per cent of the general run of institutional tuberculous patients.

I have not yet spoken about how long pneumothorax treatment should be continued and that is a problem on which the committee of the American Sanatorium Association before mentioned is working, largely by analysis of the records of those in whom treatment has been discontinued. At the risk of offering my opinion prematurely I may state the factors that seem to me to determine the advisability of allowing these lungs to reëxpand:

1. The extent and severity of the disease.
2. The amount of tissue destruction.
3. Economic and other factors affecting the patient's activities.

The second factor is a mechanical one, but important, for you cannot fill a hole or gap with nothing and the only alternative to an indefinite pneumothorax may be a thoracoplasty. We may also have to consider what is happening in the other lung, but that cannot be predicted in advance. However, we have found that with a reasonable selection of cases and careful management, twice as many contralateral lesions improved as got worse.

Finally, it seems better to be guided by rational criteria than to set up an arbitrary period over which we will continue treatment.

PRACTICAL ASPECTS OF PSYCHIATRY FOR THE GENERAL PRACTITIONER*

BY L. CODY MARSH, M.D.†

PSYCHIATRY has been one of the medical curiosities. It has lately emerged as one of the medical specialties. Psychiatry has also been one of the medical antiquities. It has now arrived as one of the medical modernities.

Only a minority of physicians now in practice received any intelligent instruction in psychiatry. Many received none at all. Not all of our class "A" schools, even now, are giving a rounded-out course in this subject. Of these last not all of them are presenting psychiatry in an engaging fashion, or in a fashion to make the run-of-the-school student realize that it has any widespread application in medicine.

So it is not surprising to those of us who have elected this specialty to find, among our colleagues in the other branches of medicine, a feeling about psychiatry quite akin to that which is common to non-medical persons. Even among physicians there is an attitude of forbidding morbidity about our science, a feeling of dread, a gladsome willingness to let the psychiatrist have full sway, and welcome.

But psychiatry is coming into her own in spite of the prejudices, the legal trammelings, and the burden of suffocating tradition. You gentlemen in the other branches of medicine do not have to contend with commitments, with locks and bars, and with the prejudices and suspicions of the public, with which we have to deal. Moreover, your patients are accustomed to you as doctors and they are generally prompt in sending for you. They send for us not at the prophylactic level of the brink of the precipice, but at the wrecking-service level of the

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†Marsh—Assistant Physician, Worcester State Hospital. For record and address of author see "This Week's Issue," page 1372.

bottom of the gorge. A striking number of people are ashamed to say they are consulting a psychiatrist.

Thus we would call your attention to a few psychiatric matters which concern you, for no one specialty can exist without the coöperation of all of the other specialties, least of all without the coöperation and understanding of the general practitioner. We would call your attention to that part of psychiatry which has been weaned from the futile antiquities of the past, a progressive psychiatry which offers, first, a prophylactic service; a progressive psychiatry which empties state hospitals by adequate treatment, and by saving the integrity of the personality before hospitalization is necessary; a progressive psychiatry which has an application for every other type of patient; a progressive psychiatry which has a helpful message for the whole medical profession, and one which may be of inestimable service to medical men severally, in helping them to understand their own personalities, their own well-springs of failure and of success.

Psychiatry is merely that care and treatment of the soul which is based upon the application of scientific common sense. But while we take the whole personality for our province, we have not preëmpted the field, for psychiatry is not only a medical science but it is one of the great social sciences. That being the case, it belongs to all of medicine as well as to all of the great social projects.

There has been much lugubrious talk about the passing of the family doctor. I submit that if the general practitioner and the medical specialist will incorporate into their activities the best of modern, progressive psychiatry, the public will have a servant, if anything, far superior to the old family doctor. It is, doubtless, true that very largely our modern medical schools have forgotten the human side of medicine in trying to produce competently trained men. Psychiatry applied to medical practice will restore this lovable human factor, but restore it with enrichments unknown even in the good old days of the family doctor.

PSYCHIATRY IN EVERYDAY LIFE

Hospital psychiatry is only an exaggeration of the psychiatry of everyday life. What you see in our wards is merely what is going on within all mankind to a lesser degree. Even this learned and distinguished group could be distributed about many of our wards and the average citizen would fail to suspect that you were "controls". Many a psychiatrist has been accosted as though he were a patient. (At times rightly so, perhaps.) The full-blown psychosis is merely the hatching of the essential savage and child in man through the thin shell of civilization. So we ask our colleagues, as well as the lay public, not to regard psychiatry as something morbidly remote from normal life but as a diffuse and integral part of life.

Political, religious, and even professional prejudices are the nuclei of the ideas of reference and paranoid trends noted on our wards. The compulsions of our drives, enthusiasms, twinges of so-called conscience, and certain types of the sense of duty, are not far remote from "hearing voices". The will to power occasionally seen in our own profession is not far from frank grandiose trends. Religious fanaticism is not the only mother of inquisitions and their corresponding tribunals. Witches are not the only ones who believe in charms. Intense nationalisms are not the only fathers of the dictator spirit. Who of us has not suffered from delusions, illusions, depressions, and possibly moments of suicidal temptation? The emotional protoplasm of us all is studded with cells of grudge, inferiority, fear, shame, and failure, which with remarkable ease may become malignant and burst the sheer cultural connective tissue capsules controlling them to metastasize throughout the personality.

PSYCHIATRY IN THE OFFICE AND AT THE BEDSIDE

Name, Address, Age, Sex, Race, and Civil Condition. Every one of these headings at the top of the general practitioner's record cards is psychiatrically significant. Many patients are ashamed of their names. There is something about the name they bear which is related to their particular inferiority feeling.

The address is equally important. This is a symbol of the patient's environment and this last may have a public health significance to him more important than the organic defect about which he consults the profession.

Age. With the average patient, the years overtake *him*, whereas with the well and happy man, he overtakes the *years*. We must help patients to do the latter.

Sex. It is simple enough to be of neuter gender, hence the drive of many individuals as well as of cults to make people of neuter gender. To be a male or a female requires emotional adjustments which many fail to make. Their very sex is a source of neuroticism.

Race. If a certain national belongs to a minority in the community, he is apt to find his situation productive of many morbid feelings.

Civil Condition. The production capacity of the divorce courts, which is little affected by the depression, is sufficient evidence that there is something wrong with the present mores of marriage. We have been too prone to say that the fault was with people. Gradually we are realizing that the trouble may be more with marriage than with those who contract it. Patients may be suffering more from marriage than from the avowed chief complaint. By the same token they may be suffering from sexual asceticism

more than they are from symptoms studied in medical school.

Maybe we have regarded these headings on our cards as mere tape to be filled in. I submit that they are of psychiatric importance to every type of patient as well as to the physician attending him.

Bedside and Office Manner. One of my greatest teachers in general medicine was famous for his bedside manner, so famous that when he built a handsome suburban home it was dubbed, "Bedside Manor." Those who got the greatest fun out of this jest were those who had the least of either bedside or office manner. They rationalized this lack by pointing to the fact that they were scientific men, as though science were above (or below) the amenities of cultured social behavior. Those who succeed in any branch of medicine need no argument for the thesis that man is much more than a digestive tube, a vertebrate heat engine. In psychiatry we make much of what we call "the psychiatric attitude", which is a combination of the attitudes of the confessor, scientist, educator, engineer, and statesman. It would seem that every type of patient should be met by such an attitude. At least this would be a practical application of psychiatry to general medicine.

Chief Complaint. I have always wished that this heading might be subdivided into two parts, (1) The Avowed Chief Complaint, and (2) The Unavowed or Unconscious Chief Complaint. Neither might be the diagnosis from a purely medical standpoint, but the unavowed complaint comes close to being the psychiatric diagnosis. I do not believe that ordinarily the general practitioner is getting the fullest thrill out of his job until he makes both the medical and psychiatric diagnoses on his patients and treats both.

I should like to cite a few cases illustrating what I mean. These patients consulted a certain internist whom I assisted, one summer, while in the medical school. The first was a business man whose chief complaint was habitual headache. The unexpressed complaint was that he had lost all faith in his religion, especially in the Virgin Birth. But this psychiatric and unexpressed complaint was only a cover for the real complaint that he had come to a complete sexual disillusionment in his married life. This was the matter about which he was in most urgent need of advice and encouragement.

A doctor complained of hemorrhoids. His unexpressed complaint was that he had worked himself into a "state of mind" because of a successful quack in his community. The real psychiatric difficulty which this shrouded was that the man was socially incompetent to build up a practice. He needed social assistance more than treatment for his hemorrhoids.

Another doctor complained of gastric ulcer. (My employer had many doctors consult him.) The unexpressed complaint was fear of a surgical operation, although the patient was a surgeon. But oddly enough, as it turned out, this patient was more afraid of life than he was of death.

A dry crusader complained of a specific infection. The unexpressed complaint was shame. He needed treatment mostly to restore his self-respect.

An old man complained of a slight prostatitis with frequency. The unexpressed chief complaint was a lonely old age. His real psychiatric difficulty was an incapacity for happiness.

A housewife complained of vague pelvic discomfort. Her husband was alcoholic and impotent. Her psychiatric complaint and diagnosis was inability to meet her sexual problem on a social-adult level.

A school-teacher complained of fear of uterine cancer. The unexpressed complaint was a feeling of frustration because she was childless and unable to sublimate this in her school teaching.

Family History. One's family history forms the very foundation of one's inferiority complex. When a patient, in reply to our questions, announces, e.g., "My uncle died of cancer," or, "I had a great aunt who had diabetes," or, "My sister has been suspected of having tuberculosis," we must realize that the patient is exposing to us, oftentimes, one of the lesions of his soul, and we should make it a point to reassure him.

Personal History. Here, too, the patient exposes the lesions of his soul in reciting certain of his past illnesses. But I doubt if it is fair to the patient to restrict him to a recital of his past physical illnesses. At least he should be given a chance to recite his emotional past. Oftentimes the mere recital of this past into sympathetic ears wins a confidence and coöperation without which medical treatment of the medical lesion proceeds unsatisfactorily, if at all.

Present Illness. When a patient tells the story of his present illness, it must be borne in mind that this recital might have an emotional value which far outweighs its organic or strictly medical significance. This has already been anticipated above under "Chief Complaint."

Physical Examination. If we recall that skin and brain come from the same embryological layer, we must realize the logic of man's sensitiveness to the exposure of his person. It is not entirely incongruous that we speak of sensitive people as "thin skinned". Then we should remind ourselves that man's body is the first layer of his environment, and he is even more sensitive to the impression which this vital layer of environment makes than to that made by his street, racial, or economic address. Successful examiners know this. Failure to realize it may account for many failures in private practice.

Differential Diagnosis. There are men in general medicine who still practice a habit learned in their clinical school years of labeling symptoms they cannot explain scientifically as "neurotic", "hysterical", or "imaginary". May I offer the thesis that there is no such thing as an imaginary symptom? It is granted that the avowed symptom may not be susceptible of proof, but be assured that it is never imaginary in the sense that there is no human foundation for it. These symptoms are comparable to referred pain and must be traced to their origins. No symptoms are to be taken more seriously and none should be more challenging than those frequently labeled, "neurotic", "hysterical", or "imaginary". The writer believes that this conception is one of the most important which psychiatry has to offer the general practitioner. The habit of using these expressions is reminiscent of such loose terms as "cardiorenal disease", "heart trouble", "lung trouble", and the like. That is, a case with a psychiatric slant is not diagnosed by such terms as neurotic, hysterical and imaginary, any more than we have diagnosed a pulmonary disease by calling it "lung trouble".

Treatment. Another idea indigenous to many medical schools is that when it comes to treatment of those with neurotic complaints we should resort to a sort of medical chicanery,—valerian, asafoetida, bromides, and placebos. Of course, these may be palliative and tide a patient over for a time, but such methods do not attack the lesion. In both general and special medicine we frequently treat symptoms as such, but we are primarily and finally interested in the treatment of the underlying lesion. It is possible to discover and treat most psychiatric lesions, especially in their early stages, in general practice. But these lesions are rarely expressed in the chief complaint.

I hope, some day, to see textbooks of general medicine and surgery in which there is a paragraph in the description of the more important diseases which is devoted solely to the psychiatric element. There is a psychiatry of sickness in otherwise normal people. The things which sick people think about, worry about, their doubts and fears,—these are a part of the psychiatry of every sick man. They should receive attention in every therapeutic plan.

The surgical patient, both before and after operation, presents a psychiatric phase which should be dealt with fully. The fear of the anesthetic, fear of dying during operation, fear lest the operation is not successful,—these form part of the psychiatry of the surgical case.

Children and adults, men and women, to mention but a few categories, offer certain modifications of the psychiatry of human sickness.

Then there is the psychiatry of special diseases, of cancer, of tuberculosis, of venereal disease, of pneumonia, of smallpox. The obstetrical case and other special surgical conditions present their respective and specific psychiatries.

Under this caption I cannot refrain from asking if a state system of medicine would be very much concerned with the psychiatric care of patients in the non-psychiatric practices. Massachusetts has an unusually progressive and humane psychiatric service, but on the whole, State psychiatry does not suggest a favorable answer to the above question.

PSYCHIATRY AND THE PROFESSION AT LARGE

Whence all this clamoring for State medicine? Is it in part due to the failure of non-governmental medicine to meet the new social implications of our profession? I was in Siberia during a period when I witnessed the fall of the White Russians and the rise and spread of Bolshevism. It always seemed to me that the intelligent Russians could have anticipated all that the Bolsheviks demanded. But the White Russians at no time displayed the slightest realization of modern social needs. They lacked a free-flowing national libido. Their power had made them impervious to new ideas.

We see this situation in our psychiatric patients, and in many professional men, a lack of emotional facility, a failure to grow, a reluctance to meet the discipline of the open mind, rigidity of personality, an orientation for time which is only intellectual, that is, a mental realization that it is 1932 but with a social orientation of a prerevolutionary date.

So I wonder if our policies as a profession might not profit by the professional scrutiny of a progressive psychiatrist. Our journals and societies represent some splendid scientific work, but oftentimes our journals and societies appear to have forgotten the social and psychiatric implications of medicine, so lacking are they in leadership and social consciousness.

So much for the administrative and academic phases of medicine, but psychiatry should also have a place in the routine of general hospitals. It is not sufficient that the private practitioner see the psychiatric implications of his job. General hospitals may render an equally great service not only by psychiatric wards and mental hygiene clinics, but by incorporating into their entire administrative structure the psychiatric consciousness and attitude.

When I served on psychiatric admission wards I had several mental connotations for new arrivals. A "T. O. P." was a case which had been taken at the "top of the precipice". They were rather rare but always hopeful. The "M. S. C." was the "maybe some chance" case which had been picked up as he was about to plunge over the brink of reason. There were more of his kind but not enough. A commoner

variety was the "D. D." or "darn doubtful", and lastly, the "P. D. O. A.", that is "prognostically dead on arrival". When general practitioners realize the psychiatric implications of general medicine, our admission rate will be markedly reduced and those admitted will rarely be worse than the "T. O. P." group.

PSYCHIATRY AND THE INDIVIDUAL PHYSICIAN

Most men study medicine during their adolescent years, which represent the most unstable period of their lives. It would seem desirable that in our schools more consideration be given to the need of helping medical students to understand their own personalities, and also of aiding them to an appreciation of the social implications of medicine. One thing which characterized the ideal family doctor was his social consciousness. He was quite as articulate on his feet before a crowd as he was at the bedside. Moreover, he generally had ability in social organization. If we are to meet the modern challenge which is suggesting bureaucratic medicine, we must begin in our medical schools not only to train our students to function in the larger social sense but to cleanse them of personality difficulties which cramp their natural powers.

However, it is not too late for the man out in practice to avail himself of the services of psychiatry for his personality difficulties. I have seen several men, who were scientifically competent but who were failing professionally, become quite successful by means of psychiatric personality studies. Social, and therefore professional competence, is not entirely a matter of gift. Psychiatry believes we are naturally social, and successfully so, once we are rid of our emotional conflicts.

I hope to see a widespread use of mental hospitals by the general practitioner, not only that he may gain personal insight into his own emotional and professional difficulties, but that he may gain an insight into the whole psychiatric viewpoint which can be so eminently valuable to him in his practice.

In the Worcester State Hospital we always have an interesting series of student groups, psychologists, nurses, social service workers, occupational therapists, physicians, internes, medical students, and even theological students. Most of these study psychiatry not only to enrich their professional fitness, but to understand themselves. At present we are conducting a seminar for twelve of our local clergymen, who represent many creeds. Nothing could be more promising than this gesture to indicate the practical values of the next development in religion.

May I suggest that not only this hospital but that every mental hospital should give similar opportunities to general practitioners of medicine in their respective communities, not only to study psychiatry but to gain personal insight? It is a token of greatness for one to seek intelligently to know oneself.

Then may I be permitted to suggest something which is my own personal hobby in psychiatry? May I suggest that more men in general practice use group methods and thus obtain the values of crowd psychology? It seems to me that a doctor's most lasting and telling usefulness is a pedagogical one. This is not an original suggestion, but I should like to add my voice to the others in urging physicians to form classes among their patient personnel. It will save much of their time; it will accomplish much more than individual methods alone will accomplish; and it will bring into their practices the psychiatric slant which we believe to be so important.

Modern medical practice suffers from waste motion. We need insight to get effectively organized for brief and decisive action. The medical class will help to solve this problem. I believe I have proved this in psychiatric practice.

SUMMARY

1. Certain practical aspects of psychiatry applicable to the work of the general practitioner are called to the attention of the profession.

2. Because of the failure of many medical schools to teach psychiatry, or to teach it in an engaging fashion, physicians have frequently failed to see the psychiatric implications of their cases.

3. The incorporation of the so-called "psychiatric" attitude into the scheme of the general practitioner will provide doctors with a personality superior, if anything, to the much beloved family doctor.

4. There are practical applications of psychiatry to everyday life. Thus psychiatry is not something morbidly remote from normal life. It is merely a system of care and treatment for the human personality.

5. Practical psychiatric suggestions are offered for the examining room and bedside in the tasks of history-taking, examination, diagnosis and treatment of patients. Attention is called to the psychiatric angle of the common illnesses, as well as special illnesses, and surgical conditions. Every case should include consideration from the psychiatric viewpoint.

6. Physicians are urged to use the terms "neurotic" and "hysterical" warily, and never to call any symptom "imaginary".

7. Psychiatry has a message for the profession at large and suggests that all medical men become more acutely conscious of the social implications of our service to mankind.

8. The individual practitioner could enrich his professional usefulness by taking courses in

his local state hospital, both for the benefit of his patients, and to obtain insight into his own personality, thus realizing more fully his natural powers.

9. It is suggested that doctors in the field of general medicine make a wider use of their pedagogical function by teaching their patients in groups. This not only gives more patients more adequate attention, but gets more accomplished because of the compulsion at work in the group.

10. There is need of even closer rapport between psychiatry and general medicine if our alarming admission rate is to be materially reduced, mainly by getting cases early enough for a hopeful outcome.

11. Psychiatry is deeply grateful for the coöperation already given by the general practitioner. We in psychiatry have, doubtless, been remiss in making our case sufficiently engaging to win the further coöperation which we now seek.

CONCLUSIONS

1. Psychiatry is so important to the general practitioner that were the element of personality removable, the medical needs of any community could be cared for by less than a quarter of the physicians now in practice, in the opinion of the writer.

2. The general practitioner is so important to psychiatry that unless we can win his enthusiastic coöperation, we must continue to put up buildings to care for the ever-increasing and staggering burden of the so-called insane, too many of whom offer little hope of recovery because of tardy hospitalization.

NEW YORK GIRL WINS GORGAS ESSAY CONTEST

Miss Harriet Jones, a high school junior in St. Agnes School, Albany, New York, was awarded the Henry L. Doherty Prize of $500 for the winning essay on mosquitoes in the Fourth Annual Gorgas Memorial Essay Contest, June 9, 1932.

President Hoover, as Honorary President of the Institute, presented the award at the White House in the presence of a distinguished company of guests which included Mr. Henry L. Doherty, New York City, donor of awards; Sir Henry Wellcome, London, England; the surgeons general of the army, navy and public health services; the committee of national judges; Mrs. Aileen Wrightson, daughter of Gorgas; and several local officials of the Institute.

The subject of this year's contest was "Mosquitoes, Their Danger as a Menace to Health, and the Importance of Their Control." High school juniors and seniors from every State and the District of Columbia participated, and 15,000 manuscripts were submitted. The Doherty Prize of $10 was awarded each State winner, and from these papers the national winners were selected by a committee of judges composed of Dr. Hugh S. Cumming, Surgeon General, United States Public Health Service; Dr. William J. Cooper, United States Commissioner of Education; and Dr. Franklin H. Martin, Director General of the American College of Surgeons.

In discussing the problem of mosquito control Miss Jones urged government and private coöperation in underwriting the cost of proper drainage work which would destroy the breeding places of the mosquito.

State prize winners in New England are:

CONNECTICUT: Manchester—James Toman, Manchester High School.

MAINE: Augusta—Roger P. Quirion, Cony High School.

MASSACHUSETTS: North Andover—George W. Busby, Jr., Johnson High School.

NEW HAMPSHIRE: Goffstown—Hilda M. Engelhardt, Goffstown High School.

RHODE ISLAND: Pascoag—Eleanor Deane, Burrillville High School.

VERMONT: Craftsbury Common—Pearl I. Chase, Craftsbury Academy.

—*Bulletin, Gorgas Memorial Institute.*

THE GREAT INDIVIDUAL INDUSTRY

Dr. Theodore B. Appel, Secretary of Health, Commonwealth of Pennsylvania, has aptly said that one of the greatest and least-known industries is that of health, because it is an individual problem as well as a public health responsibility. One should know that in this great activity there is a $3,000,000,000 investment in hospitals. It has been conservatively estimated that nearly 1,500,000 people are engaged in the various departments of this organized effort, so that, however careless individuals may be regarding this industry, there is what may be termed a "great market" which demands a service both in material and personnel which ranks with the major industries of the nation.

Dr. Ray Lyman Wilbur, commenting on this subject, has estimated that in money loss alone $6,000,000,000 worth of lives are needlessly sacrificed each year. This can be logically considered as an indictment against the average citizen whose personal interest in his or her own physical welfare is either lacking or decidedly misplaced. A people must realize that health is not provided by the gods as are the sun, air and moisture, and, therefore, assume their personal obligation in this important matter by respecting the right-living rules that personal and community health may be maintained.

The Massachusetts Medical Society

PROCEEDINGS OF THE COUNCIL

Annual Meeting, June 8, 1932

THE annual meeting of the Council was held in the Ball Room of the Statler Hotel, Boston, Wednesday, June 8, 1932 at 12 o'clock, noon. The President, Halbert G. Stetson of Greenfield, was in the chair and the following 193 Councilors present:

BARNSTABLE
W. D. Kinney

BERKSHIRE
A. C. England
Modestino Criscitiello, Jr.
H. J. Downey
P. J. Sullivan

BRISTOL NORTH
W. H. Allen
A. R. Crandell
F. A. Hubbard

BRISTOL SOUTH
J. A. Barre
R. H. Baxter
G. W. Blood
R. B. Butler
E. F. Cody
D. J. Fennelly
E. D. Gardner
W. A. Nield
I. N. Tilden

ESSEX NORTH
H. G. Armitage
E. S. Bagnall
J. F. Burnham
H. F. Dearborn
A. P. George
T. R. Healy
J. J. McArdle
F. S. Smith
F. W. Snow
L. T. Stokes
W. D. Walker

ESSEX SOUTH
C. L. Curtis
F. W. Baldwin
N. P. Breed
J. F. Donaldson
E. B. Hallett
W. T. Hopkins
P. P. Johnson
J. F. Jordan
G. H. Kirkpatrick
A. E. Parkhurst
C. H. Phillips
J. W. Trask

FRANKLIN
A. E. Johnson, Jr.
R. A. McGillicuddy
H. G. Stetson

HAMPDEN
F. H. Allen
J. M. Birnie
G. D. Henderson
M. B. Hodskins
E. A. Knowlton
S. A. Mahoney
M. W. Pearson
A. G. Rice
G. L. Schadt
H. L. Smith
G. L. Steele

HAMPSHIRE
A. J. Bonneville

MIDDLESEX EAST
E. M. Halligan
J. H. Blaisdell
A. R. Cunningham
Richard Dutton
C. E. Montague
C. E. Ordway
R. R. Stratton

MIDDLESEX NORTH
Pierre Brunelle
A. R. Gardner
J. A. Mehan
T. A. Stamas
F. E. Varney

MIDDLESEX SOUTH
F. W. Gay
C. F. Atwood
H. T. Baldwin
E. W. Barron
C. F. K. Bean
E. H. Bigelow
A. H. Blake
W. T. Burke
W. H. Crosby
D. F. Cummings
A. W. Dudley
H. Q. Gallupe
F. A. Higginbotham
N. M. Hunter
C. M. Hutchinson
L. H. Jack
F. R. Jouett
H. J. Kearney
E. D. Leonard
A. A. Levi
Edward Mellus
C. E. Mongan
F. L. Morse
J. P. Nelligan
Dwight O'Hara
W. D. Reid
J. W. Sever
F. G. Smith
C. H. Staples
H. J. Walcott
W. S. Whittemore
Alfred Worcester

NORFOLK
J. W. Ball
F. J. Bailey
Henry Baker
F. G. Balch
A. S. Begg
D. N. Blakely
W. L. Burrage
W. S. Burrage
A. H. Davison
D. G. Eldridge
C. B. Faunce, Jr.
J. I. Grover
J. B. Hall
G. W. Kaan
W. C. Kite
W. A. Lane
J. S. H. Leard
C. L. MacGray
Charles Malone
F. P. McCarthy
S. F. McKeen
T. J. Murphy
W. R. Ohler
Frederick Reis
S. A. Robins
C. A. Rowe
H. F. R. Watts
W. A. White
W. H. Young

NORFOLK SOUTH
C. S. Adams
W. G. Curtis
G. V. Higgins
F. E. Jones
N. R. Pillsbury
C. A. Sullivan

PLYMOUTH
C. G. Miles
P. H. Leavitt
T. H. McCarthy
J. J. McNamara
F. W. Murdock
A. C. Smith

SUFFOLK
W. H. Robey
A. W. Allen
A. E. Austin
J. W. Bartol
G. H. Bigelow
Gerald Blake
W. B. Breed
W. J. Brickley
C. S. Butler
David Cheever
R. C. Cochrane
W. P. Cross
Lincoln Davis
R. L. DeNormandie
W. H. Ensworth
Reginald Fitz
H. W. Goodall
R. B. Greenough
John Homans
H. T. Hutchins
E. P. Joslin
T. H. Lanman
L. S. McKittrick
T. J. O'Brien
A. K. Paine
W. S. Parker
Louisa Paine Tingley
J. R. Torbert
F. A. Washburn
Conrad Wesselhoeft

WORCESTER
E. R. Leib
J. C. Austin
W. P. Bowers
L. R. Bragg
W. J. Delahanty
G. A. Dix
G. E. Emery
M. F. Fallon
J. J. Goodwin
David Harrower
E. L. Hunt
A. W. Marsh
E. C. Miller
J. W. O'Connor
W. C. Seelye
F. H. Washburn
R. P. Watkins
S. B. Woodward

WORCESTER NORTH
R. A. Rice
F. R. Dame
A. F. Lowell
H. R. Nye
W. F. Sawyer

The President called to order and the Secretary read the minutes of the February meeting in abstract. *Voted*, To accept the minutes as read and as printed in the official organ.

The following members of the Nominating Committee, or their alternates, answered to their names and retired to deliberate:

Barnstable: W. D. Kinney; *Berkshire:* H. J. Downey; *Bristol North:* F. A. Hubbard; *Bristol South:* E. F. Cody; *Essex North:* J. F. Burnham; *Essex South:* A. E. Parkhurst; *Franklin:* R. A. McGillicuddy (Alternate); *Hampden:* G. L. Schadt; *Hampshire:* A. J. Bonneville (Al-

ternate); *Middlesex East:* Richard Dutton (Alternate); *Middlesex North:* A. R. Gardner (Alternate); *Middlesex South:* A. W. Dudley; *Norfolk:* D. G. Eldridge; *Norfolk South:* C. A. Sullivan; *Plymouth:* J. J. McNamara (Alternate); *Suffolk:* J. W. Bartol; *Worcester:* David Harrower; *Worcester North:* A. F. Lowell.

The Chair read the obituaries of two Councilors.

Since the last Annual Meeting of the Society, death has taken from us two members of the Council.

Dr. Michael Thomas Sweeney, of Atlantic, aged 50, died suddenly of heart disease while visiting a patient in Quincy, July 5, 1931. He was born in North Weymouth in August, 1880 and was graduated from Georgetown (D. C.) University School of Medicine in 1906. At the time of his death Dr. Sweeney was President of the Norfolk South District Medical Society. He was a widower.

Dr. Thomas Moulton Durell died March 4, 1932 at his home in Somerville, aged 73.

He was born in Calais, Maine, in 1858 and was graduated from the Medical School of Harvard University in 1879. Dr. Durell was appointed Medical Examiner for his district early in his medical career and achieved distinction for the quality of his medico-legal work. He is survived by his wife and two sons.

He regretted to announce the death in Philadelphia the previous day of William Williams Keen, the distinguished surgeon and writer, an Honorary Fellow of the Massachusetts Medical Society, at the age of 95.

D. N. Blakely, Norfolk read the report of the Committee on Membership and Finance as follows:

Report of the Committee of Membership and Finance on Membership

Your Committee makes the following recommendations as to membership:

1. That the following named seven Fellows be allowed to retire under the provisions of Chapter I, Section 5, of the By-Laws:

1. Bacon, Gorham, Yarmouth Port.
2. Baxter, Edward Hooker, Hyde Park, with remission of dues, 1932.
3. Crittenden, Samuel Wright, Wakefield, with remission of dues, 1932.
4. Hutchinson, Claribel Merrill, Honolulu, with remission of dues, 1932.
5. Pearson, Charles Lusby, Newton, with remission of dues, 1932.
6. Tallman, Augustus Littlefield, East Boston, with remission of dues, 1930, 1931, 1932.
7. Wagner, Emma Juliet, Somerville, with remission of dues, 1930, 1931, 1932.

2. That dues of the following named two Fellows be remitted under the provisions of Chapter I, Section 6, of the By-Laws:

1. Coon, George Bailey, Greystone Park, N. J., 1930, 1931.
2. Davis, George Rufus, Marlborough, 1929, 1930, 1931, 1932.

3. That the following named seven Fellows be allowed to resign under the provisions of Chapter I, Section 7, of the By-Laws:

1. Bloombergh, Horace Dechamps, Newton Center, with remission of dues, 1932.
2. Burrows, Marion Cowan, Lynn, with remission of dues, 1929, 1930, 1931, 1932.
3. Jensen, William Christian, Utica, N. Y., with remission of dues, 1930, 1931, 1932.
4. Lewis, Edwin Ray, Fitchburg, with remission of dues, 1932.
5. Ross, Margaret Blanche, Rumford, R. I., with remission of dues, 1932.
6. Whitney, Arthur Thomas, Houlton, Me., with remission of dues, 1931, 1932.
7. Wright, Leslie Hurd, Rochester, N. Y., with remission of dues, 1931, 1932.

4. That the following named sixteen Fellows be deprived of the privileges of Fellowship under the provisions of Chapter I, Section 8, Clause (a) of the By-Laws:

1. Bakst, Jacob Benjamin, Lynn.
2. Buck, Clifton Leon, Danvers.
3. Burack, Abraham, Brockton.
4. Herlihy, David Joseph, Arlington.
5. Killelea, Edward Vincent, Fitchburg.
6. Levine, Elijah Louis, Lynn.
7. Manoogian, Bysant John, Peabody.
8. Nugent, Arthur John, Framingham.
9. Parker, Ernest Lawrence, Hingham.
10. Prior, Earle Francis, Malden.
11. Robinson, Bernard Herman, Roxbury.
12. Taveira, Arthur Joaquim, New Bedford.
13. Thompson, John Stephen, Cambridge.
14. Tynan, Joseph Patrick, South Boston.
15. Wainshel, Percy William, Lynn.
16. Zarrella, Angelo Mario, Lynn.

5. That the following named Fellow be deprived of the privileges of Fellowship under the provisions of Chapter I, Section 8, Clause (c) of the By-Laws:

1. McCue, James Patrick, Hudson.

This recommendation follows the action of the Committee on Ethics and Discipline which voted unanimously at its meeting on May 24, 1932, to recommend that James Patrick McCue of 8 Main Street, Hudson, be deprived of the privileges of Fellowship because in the Middlesex Criminal Court, on April 27, 1932, he was found guilty of conspiracy to steal from three insurance companies and sentenced to one year in the house of correction.

6. That the following named two Fellows be allowed to change their membership from one District Society to another without change of legal residence, under the provisions of Chapter III, Section 3, of the By-Laws:

One from Norfolk to Suffolk

1. Siscoe, Dwight Lewis, Brookline.

One from Suffolk to Norfolk

1. Scannell, David Daniel, Jamaica Plain.

David N. Blakely, *Chairman.*

Upon motion duly made and seconded it was accepted and its recommendations adopted.

David Cheever read the report of the Committee on Ethics and Discipline (See Appendix No. 1) and it was accepted.

T. H. Lanman, Chairman of the Committee of Arrangements, announced that he should like to bring before the Council the propriety of choosing the date and place of the next annual meeting at this meeting, as outlined in a resolution submitted at the meeting last October. He would suggest the second Wednesday of June, 1933, and the place, Boston, according to the terms of the By-Laws, Chapter II, Section 1.

He announced that Dr. Winthrop Adams, in charge of the United States Veterans Administration Hospital at Bedford, would be glad to have Fellows of the society inspect that institution where 640 cases of mental disease are now housed.

P. P. Johnson, Chairman of the Committee on Medical Education and Medical Diplomas, reported for that committee that they had attended to the usual duties as regards medical diplomas and also had required a personal interview from candidates who were not graduates of medical colleges which are approved by the Council. This interview, in his opinion, gave the committee a much better basis for judgment as to the qualifications of these candidates, a practice which should be continued. As to the Combined Committee on Medical Education and Medical Diplomas and the Committee on State and National Legislation, that has been considering an improved medical practice act for the Commonwealth, he said he wanted to report progress. The committee had had numerous meetings during the year and had accumulated many data and had come to definite conclusions as to what changes should be made but they have felt that the time was inopportune to take action. His report was accepted.

T. J. O'Brien presented the report of the Committee on State and National Legislation, previously printed and mailed to the Councilors (See Appendix No. 2). The report was accepted by vote.

Dwight O'Hara read the report of the Committee on Public Health and also that of the Sub-Committee on Public Education (See Appendix No. 3). The question of the propriety of giving out to the public press the names of the physicians who prepare broadcasts and the names of the broadcasters, often the same, was discussed at length by the following Councilors: R. B. Greenough, Dwight O'Hara, J. W. Sever, C. G. Miles, David Cheever, G. D. Henderson, E. S. Bagnall, Edward Mellus, J. F. Burnham, and on motion duly made, and amended by Dr. Burnham, that the Committee on Public Health be instructed to continue the same system of preparing, issuing and printing broadcasts as in the past, the report was accepted by vote.

F. G. Balch presented the report of the Committee on Malpractice Defence (See Appendix No. 4) and it was accepted. He moved that the following words be inserted in the fifth line of Article *First*, page 28 of the 1928 edition of the Digest, By-Laws, Code of Ethics and Malpractice Act, after the word "society": "and were at the time of the alleged malpractice". Said motion, being duly seconded, was adopted without dissent.

The report of the committee appointed by the Council to consider the petition for restoration to the privileges of fellowship of Frederick P. Lowenstein of Springfield, recommending that he be restored under the usual conditions, was read by the Secretary and discussed by seven Councilors, whereupon, on motion duly seconded it was *Voted*, That said petition be referred back to the committee for further consideration and that the matter be laid on the table for one year. The report on a similar petition for restoration by Charles L. Furcolo of Springfield, recommending restoration under the usual conditions, was read by the Secretary and discussed by three Councilors and on motion, duly seconded it was *Voted*, That said petition be laid on the table for one year. On a voice vote the Chair declared the motion carried, but the vote being doubted a rising vote was taken and the motion declared adopted, Ayes 107, Noes 33.

On nomination by the Chair the following committees were appointed by the Council to consider petitions for restoration to the privileges of fellowship: For Charles W. Hoyt of Hingham: O. H. Howe, J. A. Peterson, C. A. Sullivan. For Michael J. Kelley of Watertown: A. H. Blake, J. J. Boyle, W. G. Brousseau.

E. F. Cody, Bristol South, for the Nominating Committee presented the following list of nominations:

For President: Halbert G. Stetson, of Greenfield
For Vice-President: Walter A. Lane, of Milton
For Secretary: Walter L. Burrage, of Brookline
For Treasurer: Charles S. Butler, of Boston
For Orator: Channing Frothingham, of Boston.

On motion by David Harrower, Worcester, duly seconded, it was *Voted*, That each Councilor be requested to refrain from voting and that the Secretary be instructed to cast one ballot for the list of nominees as presented. The Secretary having announced the casting of the ballot the Chair declared the above-named nominees duly elected to their respective offices for the ensuing year.

The Council recessed from 1:30 to 2 P. M. for the Cotting Luncheon. On reconvening in the Georgian Room at 2 P. M. the Secretary read the report of the Committee on Publications which had been handed in (See Appendix No. 5) and it was accepted by vote as was the report of the Committee on the New England Medical Council, read by W. P. Bowers (See Appendix No. 6). T. J. O'Brien, Suffolk, presented the report of the Committee on Permanent Home (See Appendix No. 7) and it was adopted. W. A. Lane, Norfolk, said that at the February meeting of the Council the report of the Committee on Public Relations had been laid on the table. He moved that it be taken from the table and offered a substitute report, one which had been printed and sent to each Councilor. The motion was duly seconded and carried (See Appendix No. 8 for the report). He then moved that the recommendations of this

report, the last two pages of the pamphlet, be accepted, and it was so voted. The Chair called attention to the enormous amount of work the committee had put into the subject; many members had come from long distances; the attendance had been from 80 to 85 per cent at each meeting and he thought that they had worked out a really satisfactory job. On nomination by the Chair the following committees were appointed by vote of the Council:

STANDING COMMITTEES

Committee of Arrangements

F. H. Colby, G. P. Reynolds, W. M. Shedden, W. R. Morrison, Horatio Rogers.

Committee on Publications

Homer Gage, J. W. Bartol, R. I. Lee, R. B. Osgood, E. W. Taylor.

Committee on Membership and Finance

D. N. Blakely, Gilman Osgood, G. C. Caner, J. E. Fish, H. F. Newton.

Committee on Ethics and Discipline

David Cheever, W. D. Ruston, S. F. McKeen, A. C. Smith, R. L. DeNormandie.

Committee on Medical Education and Medical Diplomas

Reginald Fitz, C. H. Lawrence, C. A. Sparrow, E. S. Calderwood, E. P. Bagg, Jr.

Committee on State and National Legislation

H. G. Stetson, T. J. O'Brien, F. E. Jones, A. W. Marsh, Shields Warren.

Committee on Public Health

Dwight O'Hara, E. F. Cody, F. G. Curtis, G. N. Hoeffel, G. D. Henderson.

Committee on Malpractice Defence

F. G. Balch, E. D. Gardner, F. B. Sweet, R. P. Watkins, A. W. Allen.

SPECIAL COMMITTEES

Committee on New England Medical Council

W. P. Bowers, B. W. Paddock, T. H. Lanman, J. M. Birnie, H. G. Stetson.

Committee on Cancer

W. P. Graves, G. H. Bigelow, F. G. Balch, P. E. Truesdale, G. F. Martin.

Representatives to the Massachusetts Central Health Council

Administrative Board
Dwight O'Hara.

District Representatives
Eastern: E. P. Joslin, A. W. Dudley.
Northeastern: J. A. Mehan, F. W. Snow.
Southeastern: W. D. Kinney, C. P. Curley.
Central: G. D. Henderson, E. C. Miller.
Western: H. J. Downey, R. J. Carpenter.

Committee on Public Education

(A sub-committee of the Standing Committee on Public Health)

G. R. Minot, W. H. Robey, F. J. Cotton, F. C. Irving, R. M. Smith, E. H. Place, C. C. Simmons, J. H. Pratt, H. W. Stevens, J. B. Ayer, H. P. Mosher, R. B. Osgood, F. R. Ober, E. P. Joslin, J. D. Barney, H. L. Lombard.

E. H. Bigelow, Middlesex South, asked as to the status of the Committee on Public Relations, which had just submitted such an admirable report, was it a continuing committee, a permanent committee or a standing committee? This was discussed by the Chair, F. H. Allen, Hampden, W. A. Lane, Norfolk, M. W. Pearson, Hampden, J. H. Blaisdell, Middlesex East, the Secretary, C. E. Mongan, Middlesex South, F. P. McCarthy, Norfolk, S. B. Woodward, Worcester and J. A. Mehan, Middlesex North. On motion, duly seconded it was *Voted*, That each District Medical Society is to elect a member of the Committee on Public Relations every year, the feeling of the Council being that if a member has made good, has attended meetings and has shown sufficient interest, that he should be reëlected from year to year, so that the committee may have the benefit of continuity in office of their members.

T. J. O'Brien, Suffolk, presented an amendment of one word in the proposed amendment to Chapter VII, of the By-Laws, which had been offered by him at the February meeting of the Council, namely to substitute the word "five" for the word "seven" in the second line, so that the amendment should read: "Chapter VII, Section 9. The Committee on Permanent Home shall consist of five fellows." A motion that the revised reading be adopted was seconded and passed without dissent.

C. E. Mongan, Middlesex South, took the floor and called attention to the first recommendation of the report of the Committee on Public Relations, namely: "That the Massachusetts Medical Society, in coöperation with the Massachusetts Department of Public Health, in so far as is advisable, shall promote postgraduate medical educational programs for the Fellows of the Society." He thought that some machinery was needed to carry out this recommendation; that the Society should proceed carefully and not too hastily; that it should do more for the Fellows and should go out to them and not ask them to come to the Society; that postgraduate instruction is much needed in the ranks of the profession; that a committee should be appointed to take the matter in charge. Therefore he offered this motion: That a committee be and is hereby created to plan and put into effect a system of postgraduate medical instruction in the eighteen Districts of the State of Massachusetts, consisting of the chairman and secretary of each of the six Sections of the Society together with one member of the committee for each Section, a man who is preferably a teacher in a Class A medical school.

R. B. Greenough, Suffolk, discussed the motion, explaining that there were many different methods by which postgraduate education might be accomplished. One specific instance of such instruction would be explained by C. L.

Scudder of Boston as to the treatment of fractures, Dr. Scudder being a member of a fracture committee of the New England Surgical Society, if the Council so wished. He thought that the matter of postgraduate instruction should be referred to the Standing Committee on Public Health. W. A. Lane, Norfolk, thought it should be referred to the Standing Committee on Medical Education and Medical Diplomas as did J. F. Burnham, Essex North. Sections 5 and 7 of Chapter VII of the By-Laws on the standing committees defining the duties of these two committees were read to the Council. Dr. Mongan's motion having been seconded was passed by a voice vote.

Charles L. Scudder addressed the Council. He said that interest in professional matters although keen had not been productive of better treatment of fractures; often the treatment was atrociously bad. Industry is demanding trained and competent men in order to secure satisfactory results and the profession must recognize this demand. The New England Surgical Society had formed a committee of three to go to the physician and to stress the limits of fracture treatment and to demonstrate the approved emergency treatment of fractures. To carry out a program requires the coöperation of each state medical society. He would like endorsement and any financial assistance the Massachusetts Medical Society could give. R. B. Greenough explained at length the different forms of postgraduate instruction. W. P. Bowers, Worcester, said that he was in favor of the concrete plan of Dr. Scudder as to instruction in the treatment of fractures and thought that the Council should give definite indorsement to it and vote a moderate appropriation of money to assist that committee so he *Moved*, That the Council hereby indorses the plan for postgraduate instruction in the treatment of fractures of the Fracture Committee of the New England Surgical Society, as outlined to the Council this day by Dr. Charles L. Scudder of Boston, a member of that committee, and that a portion of an appropriation not to exceed $500 to the new Committee on Postgraduate Medical Instruction, be devoted to the furtherance of the program of the said fracture committee, in the State of Massachusetts. The motion was seconded by Dr. Mongan. The Chair called attention to the fact that he had decided that this appropriation of $500 was an extraordinary appropriation and, under the terms of Section 8, Chapter IV, of the By-Laws must be submitted to the Standing Committee on Membership and Finance for a favorable recommendation. The motion being put was adopted by a voice vote.

As regards the place and time of the next annual meeting it was *Voted*, To hold the next annual meeting of the Society in Boston, June 12, 13, 14, 1933.

At the request of J. A. Mehan, Middlesex North, the Secretary reported that he had received a vote of that District society indorsing the first report of the Committee on Public Relations and that the vote was on file.

There being no further business it was voted to adjourn at 3:35 P. M.

WALTER L. BURRAGE,
Secretary.

APPENDIX TO THE PROCEEDINGS OF THE COUNCIL

APPENDIX NO. 1

REPORT OF THE COMMITTEE ON ETHICS AND DISCIPLINE

The Committee held ten meetings during the year and investigated charges of unethical conduct against twenty-eight Fellows of the Society. Hearings were accorded to seven of these men, and in six of these instances the facts were reported to the President with the recommendation that the defendant be admonished for violation of the Code of Ethics. One Fellow, convicted by the Court for an act involving moral turpitude, was recommended to the Council for deprivation of the privileges of Fellowship and the recommendation sent to the Committee on Membership and Finance for similar action, under the terms of Chapter I, Section 8, clause (c) of the By-Laws.

The admonitions were recommended for the following violations of the Code of Ethics: for making an untrue statement as to qualifications for practice; for making an extortionate charge for alleged professional services to a person who had been instantly killed in a motor accident; for using both illustrations and text from a well-known textbook, without giving credit therefor, in the preparation of a scientific paper in a medical journal; for promoting and having a financial interest in a fraudulent scheme for sickness insurance; for writing an article in a lay magazine disparaging generally accepted methods of treatment and advocating other methods held by prevailing medical opinion to be unjustifiably radical; for the signing of a death certificate falsely. The Fellow who was recommended for deprivation of Fellowship under Chapter I, Section 8, clause (c) had been found guilty and sentenced by the Court for conspiracy to steal from three insurance companies.

In numerous other instances where no cause was found to recommend disciplinary action, the Committee remonstrated in a friendly way with certain Fellows whose actions were thought to be ill-considered or regretable from the point of view of the best interests of the medical profession. These matters related chiefly to "write-ups" in the lay press savoring of self-advertising, inconsiderate treatment of physicians by consultants or medical representatives of insurance companies, complaints about excessive fees, and the adjustment of misunderstandings between physicians. The Committee has come to feel that one of the ways in which it can be of real service is to afford a medium for the frank discussion of grievances by physician and layman alike,—grievances which if denied free expression create emotional stresses which can often be dissipated if brought to the light of day.

At the meeting of the Council in October, the Committee reported the verdict of the full bench

of the Supreme Court in the Ott case which, while sustaining the action of the single justice in ordering the restoration of Dr. Ott's license to practice, interpreted the provisions of the Medical Practice Act to mean that a physician whose license to practice has been revoked by the Board of Registration in Medicine, shall not have the right of appeal (in the legal sense) to the Supreme Court, and of a retrial upon the facts, and that in any review by the Court of the proceedings before the Board, there shall be a strong presumption in favor of the correctness of the Board's decision, which must be shown to be clearly wrong before it may be revoked. The Committee on Ethics and Discipline called attention to the lack of protection to physicians afforded by this decision, and contrasted it unfavorably with the full right of trial before the Supreme Court enjoyed by lawyers who may be threatened with disbarment. On December 17, 1931, the Committee held a conference with the combined committees on Medical Education and Medical Diplomas, and on State and National Legislation, to whom has been entrusted by the Council the duty of making a study of and recommending desirable changes in the Medical Practice Act. The Committee on Ethics and Discipline made representation to the combined committee of the necessity of attempting to have the Legislature modify the Act to the end that a full right of appeal from decisions of the State Board of Registration to the Supreme Court of Massachusetts may be enjoyed by the physician. An informal vote of the three Committees, to ascertain the opinion of those present, indicated a nearly unanimous approval of this viewpoint. The matter is therefore not in the hands of the Committee on Ethics and Discipline, but rests with the combined committee which is investigating the whole subject.

Respectfully submitted:

DAVID CHEEVER, *Chairman*,
WARREN D. RUSTON,
SYLVESTER F. MCKEEN,
ALFRED C. SMITH,
R. L. DENORMANDIE.

APPENDIX NO. 2

REPORT OF THE COMMITTEE ON STATE AND NATIONAL LEGISLATION

At least fifty bills influencing the practicing of the healing art were introduced for the consideration of the Legislature of 1932. A study was made of the groups proposing the various bills and it was found that there was no particular organization directing the movement as a whole. Some introduced bills apparently for the publicity obtained at a hearing, while others had idealistic views on the subject and a few were actuated by a spirit of hatred or revenge against some member of our profession. One organized group opposed vaccination, another favored certain restrictions in the teaching of physiology, and a third favored the support of a medical cult.

Several efforts were made to create a state university and also to confer new degrees in existing colleges which do not have that right. These bills were defeated. The attempt to have health clinics at certain beach resorts in certain cities and towns, under the direction of the State Board of Health, was defeated, and bills to establish and maintain cancer clinics and provide hospital facilities for the care and treatment of persons suffering from rheumatism and kindred ailments were referred to the next annual session. The establishment of State Medicine on a war-time basis was defeated, and so were the efforts to create a Medical Research Board and to compel surgeons and obstetricians to comply with unreasonable requirements concerning the disposition of pathological specimens. These bills received but little support and were quickly disposed of in their respective committees. The petition to create a board of examination and registration to regulate the practice of magnetic healers was given leave to withdraw.

The request that a board of automobile personal injury medical examiners be established in the Department of Public Works was defeated, as was the bill to provide payment of reasonable charges of charitable hospitals in personal injury cases under the compulsory motor vehicle insurance law. A bill to regulate the recovery of compensation for a hernia under the Workmen's Compensation Law was given leave to withdraw, as was the petition relative to the appointment and fees of physicians who make examinations under the laws relating to compensation for industrial accidents.

The vaccination bill was reported adversely by the Committee on Public Health and was defeated in both House and Senate. No satisfactory explanation could be obtained for this unexpected result.

The attempt to interfere with the present law relative to the promotion of anatomical science and disposition of bodies of certain diseased persons was given leave to withdraw, as well as the effort to penalize certain experiments and operations on live dogs. If these bills were passed, it would seriously interfere with the present method of teaching medicine in this State.

Your committee is pleased to report that no adverse legislation was passed. The defeat of our one constructive measure was the failure to have the vaccination bill accepted.

The hearing on the chiropractic initiative petition was a lively one and the attendance was even greater than usual. The Committee on State Administration eventually reported against the bill by a vote of 8 to 7. The House accepted the report by a vote of 151 to 50 and the Senate concurred 21 to 13. By obtaining five thousand more signatures of legalized voters and depositing them with the office of the Secretary of State on or before the first Wednesday in August, the chiropractors may have a referendum placed on the November ballot. This will be submitted to the voters on a yes and no basis. Your committee realizes that much campaigning must be done in order to defeat this measure. The officers of the Massachusetts Pharmaceutical Association have been interviewed and they have promised to render every possible aid in opposing this cult of drugless healers. Efforts will be made to enlist the active coöperation of the dentists, nurses, pharmaceutical houses and instrument dealers. An appeal will be made to the more intellectual members of our citizens and to the many women's clubs. While this will be helpful, the real work must be done by the several members of the medical profession. We propose to have placards printed for distribution in the different drugstores that the general public may be well informed of the principles advocated by us and circulars should be provided for each physician in the State that his patients may be properly instructed before the election. Leaders in both parties have approved of these methods and we feel that with the State-wide distribution of facts to the general public, success will reward our efforts.

We are not dismayed or overconfident, but we do feel that if each member of our Society will influence one hundred votes, there will be no question of our victory.

We wish to take this opportunity of expressing our appreciation to the officers of the district societies, to the members of the Auxiliary Committee and to our many influential lay friends whose assistance has enabled us to present our principles to the members of the Legislature throughout the State. A con-

tinuation of these methods must be emphasized in the present campaign.

Respectfully submitted,

HALBERT G. STETSON,
THOMAS J. O'BRIEN,
FREDERICK E. JONES,
ARTHUR W. MARSH,
SHIELDS WARREN.

APPENDIX NO. 3

REPORT OF THE COMMITTEE ON PUBLIC HEALTH

Several times recently it has been stated that the Massachusetts Medical Society should provide postgraduate instruction for its Fellows. Inasmuch as this Committee is charged with this duty according to chapter VII, section 7, of the By-Laws, we have considered the subject.

Postgraduate instruction is now being obtained mainly in two ways. First, by local groups or clubs who have themselves arranged their programs, and secondly, by individuals who have taken advantage of the facilities already available in the schools and hospitals. The Committee has held a conference with our president, Dr. Stetson, the deans of the three medical schools in Boston, and certain other interested physicians. At this conference it was generally agreed that the physicians of Massachusetts were apparently not availing themselves of the opportunities now existing for postgraduate medical instruction. It would seem that any action by the Society should include the encouragement of its Fellows to use the present facilities or perhaps to influence the present facilities in such a way that they would be more popular. The Committee might act as a contact bureau between the Fellows of the Society and the organized courses now being offered. It proposes to study the question further, and will welcome suggestions from Fellows in any part of the State.

Respectfully submitted,

DWIGHT O'HARA, *Chairman.*

REPORT OF THE COMMITTEE ON PUBLIC EDUCATION, A SUB-COMMITTEE OF THE COMMITTEE ON PUBLIC HEALTH

During the past year the Committee on Public Education has continued to coöperate with the State Department of Health, by supplying answers to questions sent to the "Health Forum", and by preparing or securing, and broadcasting the weekly ten minute "Health Talks." The programs of these talks, and in many instances the talks themselves have been published in the *Journal*. The daily papers are not now at all interested in this work, but they would be if they could use the names of the Fellows who write and read the broadcasts. It is felt by some that our refusal to allow the use of the doctors' names for publication in the press and the radio programs reduces to a fraction whatever good the broadcasts themselves may be doing. The Committee is considering a trial of this sort of publicity, for it feels that much of the material that has been presented is worthy of more widespread dissemination. The reactions of both the public and the Society, which such a trial might evoke, would at least be a guide to future policy.

Respectfully submitted,

DWIGHT O'HARA, *Chairman.*

APPENDIX NO. 4

REPORT OF THE COMMITTEE ON MALPRACTICE DEFENCE

The routine work has been attended to by the chairman but when questions have come up that needed the opinion of the whole Committee, they have been taken up with the various members by letter or telephone.

One case was tried and lost. It was practically certain that we could not win but the defendant was not willing to settle at any figure acceptable to the plaintiff. This case has been pending since 1925.

Few cases come to trial. Lawyers do not care to push cases defended by the Society knowing that the chances of a compromise are very small and that any money they may get will not be paid by the Society.

Article 5 of the Malpractice Defence Act may forbid us to pay for medical experts in a case. As a rule, doctors make no charge to the Society but in one or two instances it has been much less expensive for the Society to pay one expert fee than to defend the case.

It seems advisable that Article 1 be changed so that it shall read in line five after the word "Society": "and were at the time of the alleged malpractice". As it stands now, if a non-member sees a suit threatening, he can then join the Society and take advantage of our protection.

It seems as if the number of suits against physicians is diminishing. According to the figures given to our lawyers by the two companies doing most of the Massachusetts malpractice insurance, there has been a marked decrease in the number of suits entered from 1927 to 1931 and a very satisfactory number of verdicts for the defendant. Nearly a quarter of the cases last year were settled by a payment to the plaintiff but a very much larger proportion of the cases were disposed of without a payment. As more suits are fought and won or settled without payment, we believe that suing doctors will become more and more unpopular.

It seems advisable to call the attention of Retired Fellows of the Society to the fact that if they do any practice at all after they retire, it is at their own risk unless they carry other insurance, as under Article 1 the Society can defend only active members.

F. G. BALCH, *Chairman,*
ARTHUR W. ALLEN,
EDWIN D. GARDNER,
FREDERICK B. SWEET,
ROYAL P. WATKINS.

APPENDIX NO. 5

REPORT OF THE COMMITTEE ON PUBLICATIONS

The New England Journal of Medicine

The *Journal* has continued to publish the proceedings of the Massachusetts Medical Society, the New Hampshire Medical Society, the Vermont State Medical Society, the New England Surgical Society, the New England Pediatric Society, the New England Obstetrical and Gynecological Society, the Boston Surgical Society, the New Hampshire Surgical Club and the Neisserian Medical Society as the official organ of these several bodies.

In addition the Massachusetts Medico-Legal Society, the New England Branch of the American Urological Society and the New England Medical Council, although not in the group of the Societies using the *Journal* as their official organ, have practically joined those mentioned above in sending their reports for publication.

The regular reports contributed by the District

Societies and many local medical organizations seem to indicate a growing spirit of coöperation throughout the state. Scientific papers have been contributed by 235 authors, and 141 editorials have been published which together with correspondence, news items, book reviews, and miscellaneous material have required 2706 pages of reading matter. An excess of material has been offered above that for which space could be provided.

During 1931 the advertising revenue remained about the same as for 1930, but we are fearful that the next report will show some shrinkage.

In the latter part of 1931 the circulation reached the highest figure in our history with the distribution of 6548 copies. Later figures show a decline in circulation due to the number of members in arrears on the first of March. On that date, the names of members whose dues have not been paid are omitted from the mailing list of the *New England Journal of Medicine* as provided by the Council.

The cost of publishing the *Journal* for 1931 is:

Printing (*Journal* and Stock purchases)	$24,257.53	
Postage, Binding and Mailing	6,517.38	
Reprints	7,468.63	
Engraving	2,131.08	
Mass. Gen'l. Hospital, C. C. R.	1,634.46	
Index	480.06	
Office Salaries	6,023.08	
Salaries of Editors	4,237.55	
Commissions (Advertising and Subscription)	1,945.89	
Editorial Expense (Including fees for contributed editorials)	1,371.95	
Rent (The rent for the year 1932 will exceed that of previous years because of the continuance for a full year of the occupancy of the present offices. This figure will appear in the next report. The present accommodations are proving to be very satisfactory.)	1,478.74	
Office Expenses (Water, paper, envelopes, writing utensils, index and account cards, billheads, ribbons, towels, *Journal* wrappers, labels, cleaning windows, moving expenses)	2,397.67	
Collection Fees	18.25	
Discounts allowed	1,054.29	
		$61,016.56

The revenue for 1931 is:

Advertising	$26,368.68	
Books	4.18	
Engraving	1,131.54	
Envelopes	177.89	
Reprints	8,379.17	
Subscriptions (Exclusive of M. M. S.)	7,027.88	
New Hampshire State Medical Society	493.89	
Vermont State Medical Society	391.82	
Miscellaneous (Misc. Sales—single copies of *Journal* and Interest and Discounts)	456.72	
		$44,431.77

Clerical service has been provided for the officers and committees of the Society by the office force of the *Journal*. The demand for the service has increased since removal to the Library building.

The appropriation for the maintenance of the *Journal* was $15,000.00, all of which was used.

The unofficial publicity bureau maintained by the *Journal* is more generally appreciated as time goes on.

There has been a general spirit of coöperation on the part of officers and Fellows of the Society.

HOMER GAGE, *Chairman*.

APPENDIX NO. 6

REPORT OF THE COMMITTEE ON THE NEW ENGLAND MEDICAL COUNCIL

The New England Medical Council was organized November 17, 1926, under the leadership of the late Dr. James S. Stone of Boston and of Dr. David Parker of Manchester, New Hampshire.

The first informal meeting was attended by representative members of the New England state medical societies and there was expression of a unanimous sentiment that conferences of representatives of these organizations should be held from time to time for the discussion of matters of general interest relating to the practice of medicine. To this end, an organization was perfected under the above designation. It was voted to recommend to the state societies that delegates be appointed to attend the sessions of this Council. Since the date of organization, two meetings have been held each year in Maine, New Hampshire, Vermont, or Massachusetts, the greater number having been in Boston.

The officers for the current year are as follows:

President: Dr. George Blumer of New Haven, Connecticut

Vice-President: Dr. W. G. Ricker of St. Johnsbury, Vermont

Secretary-Treasurer: Dr. W. P. Bowers of Clinton, Massachusetts. Address, 8 The Fenway, Boston.

Executive Committee:

Dr. George Blumer, 195 Church Street, New Haven, Connecticut

Dr. D. E. Sullivan, 7 North State Street, Concord, New Hampshire

Dr. William G. Ricker, St. Johnsbury, Vermont

Dr. F. T. Fulton, 124 Waterman Street, Providence, R. I.

Dr. B. L. Bryant, 265 Hammond Street, Bangor, Maine

Dr. Walter P. Bowers, 8 The Fenway, Boston, Massachusetts.

The December, 1931, meeting was held in Boston at which time an address was delivered by Dr. Stephen Rushmore on "The Medical Practice Act" which was discussed at length by members of this Council. The proceedings of that meeting were published in the *New England Journal of Medicine*, March 3, 1932.

The meeting in March, 1932, was held in Boston and the subject of "Publicity Relating to Medicine" was discussed by Dr. Iago Galdston representing the New York Academy of Medicine, and Dr. Morris Fishbein, Editor of the *Journal of the American Medical Association*, to which the medical profession was invited. The report of this meeting will be published soon.*

Meetings of the New England Medical Council have been well attended, great interest has been shown by the members, and prominent persons qualified to entertain and instruct have been ready to deliver the addresses or discuss them. Each state is represented by five members. The proceedings of the Council have been published and copies have been sent to all who have applied for them and are on record in the archives of each of the contributing societies.

*See page 1355 of this issue.

The expenses of the December 1, 1931 meeting, plus miscellaneous expenses were $366.60, or $61.10 for each state.

The expenses of the March 10, 1932 meeting, plus miscellaneous expenses were $459.11, or $76.52 for each state.

It seems to be the consensus among the members that the proceedings of the Council have been of sufficient interest to warrant continuance of its activities.

WALTER P. BOWERS, *Secretary.*

APPENDIX NO. 7

REPORT OF THE COMMITTEE ON PERMANENT HOME

The Committee has attended to the duties assigned to it by the motion creating it at the Council Meeting on June 11, 1929.

The editorial rooms of the *New England Journal of Medicine* and the headquarters of the Massachusetts Medical Society have been located at 8 The Fenway since October 1, 1931. We have an agreement with the Boston Medical Library which continues until October 1, 1936. Unless notice in writing is given three months prior thereto of the desire of either party to terminate the agreement on said date, the agreement shall continue thereafter, but shall thereafter be terminable on either party giving the other three months' notice in writing.

Our fund now totals about $47,000.

The proposed amendment to make the Permanent Home Committee a standing committee of the Society will be submitted in today's order of business.

Respectfully submitted,

THOMAS J. O'BRIEN, M.D., *Chairman,*
Committee on Permanent Home.

APPENDIX NO. 8

REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

At a meeting with the Public Health Council and the Commissioner of Public Health on March 7, 1932, the following, which represents a part of the material, was presented by the subcommittee of the Public Relations Committee:

We greatly appreciate the courtesy you have shown in allowing us to meet with you and we come here actuated by an earnest wish to eliminate the discord that is existent, in our opinion, between the Department of Public Health and certain practitioners of medicine in this State. We believe we can cultivate a more general spirit of coöperation between the two bodies that each may work to the other's advantage and to the advantage of the public whose interests we both serve. Whatever we say is expressed dispassionately to the end that our conference may be wholly constructive.

By vote of the Council of the Massachusetts Medical Society in October, 1931, a Committee on Public Relations was appointed for the purpose, among other things, of investigating the relations between the Department of Public Health and the medical profession in this State. This Committee consists of nineteen members, one representative from each District Society and the President of the Society, who acts as Chairman. The committee, here present, is a subcommittee of five members appointed for the sole purpose of meeting with you this evening. We are instructed by the General Committee to present to you the following facts:

1. At our first meeting it was voted to confine our attentions for the present to the relations between the practitioners of the State and the Public Health Department. Enough evidence has been presented to the Committee to convince the majority of its members that up to the present time the Department of Health

a. Has encroached on the rights and privileges of a group of men legally licensed to practice medicine in the Commonwealth, thereby competing with them.

b. That certain methods which have been employed by the Department of Public Health are not ethical according to the standards of the Massachusetts Medical Society as shown by circulars or posters and statements of the relative costs of certain treatments.

2. Enough evidence has been presented to make the majority of the Committee believe that the future plans of the Department of Public Health indicate still further encroachment as shown by the hospitalization and treatment of chronic disease.

3. It is believed by the majority of the Committee that these activities are not solely advantageous to medical progress, but may represent tendencies toward the establishment of some form of State Medicine.

4. Expressions of regard and respect for the Commissioner of the Public Health Department and the members of the Public Health Council have been voiced in the meetings of the Committee. We are fully cognizant of the many benefits conferred on the practitioners by the Department, and are glad to note that there is no general animosity and that no general desire for any change in the personnel of the Department is indicated.

5. The Committee feels that the membership of the Massachusetts Medical Society represents the best that is to be found in matters pertaining to medicine in this State. Their education and training and the nature of their service entitle them to rank among the foremost citizens of the State.

6. Our Committee maintains:

a. That there is no special lack of well-trained medical men in the State. That in the personnel of the profession are to be found those who are able to undertake the management of clinics and consultations now administered by the State.

b. That there is no lack of hospitalization and medical care for the acutely ill of the State.

c. That the lack of proper hospitalization and treatment of the chronically ill is a condition arising from lack of money and equipment necessary for proper medical organization.

d. It is the unanimous opinion of the Committee that there is no demand for any form of State medical treatment aside from those already existing, which cannot be properly cared for, given the adequate equipment, by physicians already licensed to practice in the State.

In a History of the Massachusetts Medical Society, compiled by Dr. Burrage, on page 140 is quoted the resolution offered by John Jeffries to the Council on February 6, 1861: "Resolved that the Massachusetts Medical Society petition the Legislature . . . for the establishment of a State Board of Health for the purpose of looking after the sanitary interests of the people. . . . That the Board of Health have charge of the registration of Births, Marriages and Deaths and the census of all the other vital statistics of the Commonwealth. That the Board has some visitatorial power in connection with the Lunatic Hospitals and all other state charitable institutions where the sick and suffering are kept." This resolution in effect is for a sanitary and statistical board and in 1869 your establishment was effected through the Massachusetts Medical Society.

The powers and duties of the Department as given under date of February 24, 1932, by Dr. Bigelow are as follows:

"The department shall take cognizance of the interests of health and life among the citizens of the Commonwealth, make sanitary investigations and inquiries relative to the causes of disease, and especially of epidemics, the sources of mortality and the effects of localities, employments, conditions and circumstances on the public health, and relative to the sale of drugs and food and adulterations thereof; and shall gather and disseminate such information relating thereto as it considers proper for diffusion among the people. It shall advise the government concerning the location and other sanitary condition of any public institution; and shall have oversight of inland waters, sources of water supply and vaccine institutions; and may, for the use of the people of the Commonwealth, produce and distribute antitoxin and vaccine lymph and such specific material for protective inoculation, diagnosis or treatment against typhoid fever and other diseases as said department may from time to time deem it advisable to produce and distribute; and may sell, under such rules, regulations or restrictions as the Council may establish, such amounts of the various biologic products prepared or manufactured in the laboratories of the department as constitute an excess over the amounts required for the diagnosis, prevention and treatment of infectious diseases within the Commonwealth. It shall annually examine all main outlets of sewers and drainage of towns of the Commonwealth, and the effect of sewage disposal."

Apparently the ideas in this paragraph are similar to those of the resolutions of eight years previously, with the addition of the phrases concerning antitoxin and vaccine and various biologic products which are comparatively recent developments.

While the foregoing is in a sense a creed to be followed by the Department of Health, it should be recognized that the State is inclined to enlarge the functions of the Department as shown for example in the cancer program defined by the General Court.

The American Medical Association, in a resolution passed at its annual meeting in 1922, defined state medicine as follows:

"Any form of medical treatment provided, conducted, controlled or subsidized by the Federal or any state government, or a municipality, excepting such service as is provided by the Army, Navy, or Public Health Service, and that which is necessary for the control of communicable diseases, the treatment of mental diseases, the treatment of the indigent sick, and such other services as may be approved by and administered under the direction of or by a local medical society."

If we accept this definition, it would seem that the state cancer program is in fact state medicine. However, this was not at the solicitation of the Department of Public Health, but was forced upon it by legislative action and is illustrative of what will happen if the medical profession is not alive to the demands of the public. It may also be added that through its cancer program, administered by the Cancer Committee of the Massachusetts Medical Society in coöperation with the Public Health Department, Massachusetts has received well-merited praise and commendation from all parts of the country. State medicine is a name that carries various meanings to different individuals, but for practical purposes may be construed as an entrance into the field of curative medicine in competition with the individual practitioner. If the masses could be treated as such by the recommendation of certain principles, e.g., the use of iodized salt in certain districts for the prevention of goitre, there would be no apprehension that that principle was in competition with private practice.

In an inventory of the United States Health Facilities published in the *Boston Transcript* February 16, 1932, United States physicians are enumerated to the number of 143,000 and health department personnel to the number of 11,500. There are also listed dentists, nurses, hospital superintendents, osteopaths, chiropractors, professional technicians, etc., to swell the total to 1,481,111. Social organizations are not listed. It is evident then that of the medical profession in the United States approximately 8 per cent are engaged in Health Departmental Activities. Probably less than this percentage is so occupied in Massachusetts.

Is it true that the baby born of its father (M. M. S.) is now to subjugate its parent to its discipline in the practice of medicine? We do not wish to believe that that is either your intent or your desire.

We recognize that the medical profession is constantly changing and the younger men coming into the practice of medicine are more carefully trained than we of an older generation. They, however, lack the wisdom that experience alone can contribute, and among those of each generation are variations in personality, intellectuality, opportunity, ambition, inspiration and the monetary means to accomplish their aims. Also among the laity are variations in individuality, education, common sense, various degrees of capability in reaching their objectives, etc., and the superstitions of former days are more or less prevalent. Each period has its problem of education and that problem is perennially constant, which we together have to solve.

1. We believe that the medical practitioner is an ambitious individual, usually high-minded and hard-working, eager to learn as is witnessed by the large attendance and spirited discussions at the District Medical Society meetings, especially those of a clinical nature. He realizes that he is handicapped by a relatively small amount of clinical material as compared with his confrere practicing in a large metropolitan hospital. However, he is one of a great majority and we recommend for his benefit (reacting on the many thousands of sick and suffering of the Commonwealth who are under his care) that the Massachusetts Medical Society establish in coöperation with the Public Health Department, postgraduate courses throughout the year for the increase of his knowledge, skill and competence in practice. With the constant advance of the science of medicine, our difficulties in the individual case should be less acute. A single disease may be cited for illustration, e.g., diphtheria, of which, were the knowledge of prevention and treatment as even at present known and that knowledge universally applied, the disease should cease to exist.

2. We find ourselves at variance with certain practices of the Public Health Department and have to suggest that they eliminate or modify their advertising in so far as it affects clinical medicine. We recognize that their means are large and the temptations daily to get before the people the information that they feel should be disseminated. However, the Public Health Council must recognize that it is not ethical for doctors to advertise, and, except in more general terms, we believe that this should be so modified that the Public Health Department should be wholly impersonal and not appear to be in competition with or superior to the medical practitioner. This would apply more particularly to their Cancer Program and the control of contagious diseases and general hygiene and tuberculosis.

3. That the Public Health Department has an opportunity for closer coöperation in clinical work with the practitioner by means of the local influential doctors, the local boards of health and the district societies. We realize that one of our tasks is to bring before the medical profession the need of closer organization, of real cohesion and greater responsibility than at present is apparent. But we believe it must be done.

4. That they might attain their ends and con-

tribute toward the relief of the suffering by aiding the hospitals already established in subsidizing the investigation of certain of their problems of research and treatment of chronic diseases. By some such method, popular but uninformed demand would be satisfied. A leaven thus produced would tend to clarify the whole problem.

5. That there should be closer control of proselyting by nurses, social workers and personnel of the clinics or institutions according to the code of medical ethics of the Massachusetts Medical Society.

6. That they should allow the local practitioners, in so far as they are able and willing, to act as consultants in various State activities such as poliomyelitis, pneumonia, contagious diseases and preventive medicine.

You will realize that in consultations in medicine the consultant is honored by being called in this capacity and should meticulously refrain from acting or saying anything that may react to the disadvantage of the practitioner. There is good reason for this attitude, built on the foundation of many years of practice and which need not be rehearsed here, that is the basis of medical ethics and should be insisted upon in state activities.

7. We believe it might be helpful to allow the Public Relations Committee to advise and read the literature that is sent out by the State Department to lay people and organizations.

8. We suggest that through the local physicians there might be even better control of the acute contagious diseases by means of local consultations, the distribution of an authoritative and informative pamphlet relating to the incubation period of contagion, the prodromes, isolation, and control of special features. That in their activities there should be a more extensive control of the dairy products, especially in relation to tuberculosis, in that up to the present time there has been inadequate control over the cream and butter products or such frozen foods as ice cream. Certainly those are fields in which the Public Health Department has unlimited opportunities most helpful to the practitioner in medicine.

In recapitulation we recommend that your Council seriously consider our suggestions as to the limitation and modification of advertising, the elimination of proselyting, the strict adherence to the code of medical ethics of the Massachusetts Medical Society, the earnest consideration of subsidizing as applied to hospitals already established, in efforts in research in chronic diseases, and the sympathetic inclusion of local physicians in your program of consultations in clinics of all kinds and the field of preventive medicine; your coöperation in proposed postgraduate courses in clinical medicine of the Massachusetts Medical Society and advanced and continuous efforts in relation to foods, drugs, and sanitary measures. We reiterate that this committee is entirely sympathetic with you in your problems and earnestly wishes to coöperate through the Massachusetts Medical Society to bring into closer understanding with you the great body of medical practitioners in this Commonwealth.

. . . . . .

In reply under date of April 14 there was received the following from the Commissioner of Public Health:

The Public Health Council has studied carefully the statement which you were good enough to present to them at their meeting with you on March 7, particularly in the light of the very profitable discussion which followed the presentation of the statement. We wish to say that we appreciate your meeting with us and feel that it marks a real advance in the relations between official health agencies and the organized medical profession in this State, and we hope will be the forerunner of many others.

I should like to discuss the individual points raised in your statement beginning on page 5.

(1) Coöperation in postgraduate courses for physicians. This is a very fundamental suggestion since the health of the people must depend on an alert, informed medical profession, and this matter is therefore one of great concern to any health department. Through the Cancer Committee of the Society the Department has coöperated in this field with considerable success. We are just now in touch with representatives of the Obstetric and Pediatric Sections of the Society as to possible assistance that we can give in prenatal, obstetrical and postnatal courses. Other fields in which we are much interested are the early recognition of tuberculosis, gonorrhea, syphilis, and the other acute communicable diseases, the more common chronic diseases, child hygiene and the like. We are eager to develop this excellent suggestion further.

(2) Criticism of "advertising" methods, particularly as regards Cancer Clinics. As ordered by statute, cancer clinics are operating in fifteen communities. In each the local medical society has appointed a medical cancer committee, which in turn has appointed a local cancer education committee. These latter committees have done splendid work and much of the success of the cancer program in bringing persons with cancer to private offices and clinics in increasing numbers is due to them. We have used and have encouraged them to use all accepted, dignified methods of informing the public. Perhaps this whole subject of methods of public education can be taken up in detail at a subsequent meeting. It is a large subject.

(3) Closer coöperation with practitioners. This has always been our aim and we welcome the suggestion.

(4) State aid for research to established hospitals. We feel that the legality and wisdom of this suggestion need further consideration.

(5) Control of "proselytizing" by clinic staff. All official and private agencies are acutely aware of the menace of such practice to any of their programs. Such practice indicates lack of competent direction or incurable individual stupidity. Sympathetic medical direction in solving local problems will promptly end such abuses.

(6) Employment of local practitioners as consultants. Is this recommended for a continuation of the service in poliomyelitis? How should the consultants be selected? Will there not be local jealousies? In this respect the full-time man is often less open to criticism than the part-time practitioner. We have tried both, as have local boards of health, and each method has been criticized.

(7) Advice as to printed material. This suggestion is most welcome and such material has already been sent to you. We look forward to the frankest possible criticism.

(8) Again suggest the use of local consultants, also the preparation of communicable disease control pamphlets and further supervision of cream, butter and ice cream as vectors of tuberculosis. The first matter has been touched under (6). Since communicable disease control is regulated by local boards of health there may be wide variation within the State (Massachusetts is the only state without a uniform code on this matter). However, we have suggested standards which have been approved by the Public Health Committee of your Society as well as by the Massachusetts Association of Boards of Health. Over one hundred communities have adopted these. Support by members of the Society in this matter in other communities would be helpful. Most of the cream, butter and ice cream mix used in the State, except that which may be produced locally, perhaps, is pasteurized primarily for commercial reasons but incidentally contributing to the prevention of the spread of tuberculosis and other milk-

borne diseases. We feel that we are quite alive to the problem here though, of course, as in other fields we are not entirely satisfied.

In conclusion I should like to say that

(a) We look forward to the Public Relations Committee as offering a permanent professional forum where we can discuss future plans for the Department.

(b) We anticipate helpful criticism of our printed material.

(c) We hope through appropriate committees of the Society to greatly widen our coöperative efforts in the field of postgraduate medical education.

(d) We invite early suggestions as to the use of local consultants in the field of poliomyelitis so that with the Harvard Infantile Paralysis Commission we may organize for the coming summer.

(e) We should specifically ask for suggestions as to how the cancer clinic, the tuberculosis clinic and the like are to handle the very baffling situation of the person of means without a physician asking the clinic for advice as to what physician he shall visit. Here the patient has a right to assume a reasonable degree of competence in the particular field under consideration in the physicians whose names are given. What can we tell clinics to do that will be both fair to patients and to physicians?

(f) From time to time there will be other matters which we should like to feel free to take up with the Public Relations Committee.

Recommendations of the Committee on Public Relations

At a meeting on April 28 these two statements were presented to the General Committee with Doctors George H. Bigelow and Roger I. Lee present as our guests. Following a profitable discussion it was recommended

1. That the Massachusetts Medical Society in coöperation with the Massachusetts Department of Public Health, in so far as is advisable, promote postgraduate medical educational programs for the members of the Society.

2. We believe the Department of Public Health endeavors to conduct ethically its program and govern its personnel to the end that our doctors and the public may know that we are in the closest accord.

3. In relation to the close coöperation between the Department of Public Health and the practitioners we believe in the light of our discussions and recent publications that the opportunities are present for the practitioner to enter the field of preventive medicine and his obligations to the community demand that. A proper appreciation of such duties will largely eliminate such commercializing efforts in preventive medicine as are now sold to the public through the Life Extension Institute of New York City. The public is demanding information for preventive measures, while the Department of Public Health stands ready to support and forward such a movement by the practitioners in general. We recommend that the district societies take this up locally and promote such measures as may be feasible in the several communities.

4. In relation to state aid for research in established hospitals, the Committee recommends further consideration; but it is the present opinion of this Committee that further hospitalization of cases of chronic diseases be undertaken in connection with now existing institutions rather than through the establishment of new state hospitals.

5. We recommend that the district societies make available to the Department of Public Health the names of appropriate consultants who may participate in the State's local health programs and Dr. Bigelow suggests that conferences between the Public Health Committee and such qualified practitioners be held anticipatory to the particular program proposed.

6. In relation to the printed material we believe as a whole that it is excellent. It may be that, if the printed material had the sanction of the Committee on Public Health of the Massachusetts Medical Society, the endorsement of this Society might well be included with the name of the Department of Public Health.

7. Since communicable disease control is regulated by the local boards of health there is wide variation of regulations within the State (Massachusetts is the only state without a uniform code on this matter). Your Committee recommends the adoption by local boards of health of standards which have been approved by the Public Health Committee of the Massachusetts Medical Society and by the Massachusetts Association of Boards of Health. "Over one hundred communities have adopted these." Your Committee believes that a consideration of means to obtain early recognition and prevention in the venereal diseases, under the direction of the Public Health Committee of this Society in conference with the Massachusetts Public Health Council, is desirable.

We are responsive to the expressed wish of the Public Health Council that we may meet with them in the future at such times as may be available to take up other matters for future programs which will be helpful to the doctors, the Council and the public at large.

We believe that the representative from each district should be responsible to his district in informing the members as to the activities of the Committee as a whole and should at stated intervals report to the district medical society. As matters of importance occur, a special meeting or a part of a regular meeting should be given over to a discussion of the problem presented.

We earnestly urge that the individual members of the Massachusetts Medical Society do their utmost to coöperate with the Department of Public Health in their own communities and that the District Societies should assume the position of leadership and guidance in the various activities engaged in by the Department of Public Health and sponsored by the Massachusetts Medical Society.

In conclusion we feel that our gratitude should be expressed to the Public Health Council and the Commissioner of Public Health for their friendly courtesy and generous help to us. We feel that each one of the medical fraternity should welcome the spirit of earnest close coöperation and understanding that has been engendered and realize that in such close unity there is unlimited strength for accomplishment.

Respectfully submitted,

Halbert G. Stetson, *Chairman*, Franklin
J. Harper Blaisdell, Middlesex East
William G. Curtis, Norfolk South
Fred R. Dame, Worcester North
Frank H. Dunbar, Bristol North
Harry W. Goodall, Suffolk
Ernest L. Hunt, Worcester
Walter A. Lane, Norfolk
William F. MacKnight, Bristol South
Stephen A. Mahoney, Hampden
Thomas H. McCarthy, Plymouth
Richard A. McGillicuddy, Franklin
Joseph A. Mehan, Middlesex North
Charles E. Mongan, Middlesex South
Francis E. O'Brien, Hampshire
Patrick J. Sullivan, Berkshire
John I. B. Vail, Barnstable
William D. Walker, Essex North
Harper E. Whitaker, Essex South.

NEW ENGLAND MEDICAL COUNCIL

THE meeting was called to order by Dr. Blumer, President, at the Boston Medical Library on March 10, 1932 at five o'clock. Dr. Bowers, Secretary, read his report covering expenses, and upon motion duly seconded it was

Voted: That the report of the Secretary be approved.

Dr. George Young read the report of the Committee appointed to consider the paper and discussion of Mr. Locke at the meeting of the Council held on February 12, 1931 as follows:

REPORT OF THE COMMITTEE APPOINTED TO REVIEW MR. LOCKE'S PAPER ON "MALPRACTICE SUITS" AND ITS DISCUSSION

Your committee, appointed to review Mr. Locke's paper on the subject, "Malpractice Suits" and its discussion, wishes to offer the following report.

Mr. Locke's paper and its discussion by members of the various state committees of medical defense, together with Mr. Crosbie's discussion made a most interesting meeting which was very instructive to those interested in this work. Both the paper and its discussion should be read and re-read by your state boards, for your committee feels that there were points brought out by different states that could be used, by others, to their advantage.

There were represented at this meeting the three important factors in every malpractice suit: the *law, insurance* and the *doctor*. It was interesting to learn from these able speakers the reasons why patients bring malpractice suits. These reasons might well be summarized, treating the paper and discussions as one, under several important heads:

First, the modernistic demand of the public for prompt and satisfactory results.

Secondly, the habit of compromising threatened suits (in other words, settling cases where the doctor is not at fault, to avoid notoriety). There was considerable discussion on this point and expression of different opinions.

Thirdly, because doctors are becoming less sympathetic and understanding. Mr. Locke believes that we are not. He, no doubt, is thinking in terms of efficiency, while the patient's idea of service is apt to be measured by the length of time the doctor spends with him or by the amount of actual work he turns over to an assistant or nurse. It is easy to believe that, at times, the few minutes it takes to change a bandage with one's own hands, is well spent and may determine the relation between the doctor and his patient.

Fourthly, several speakers brought out the point that the patient had been taught to believe that someone should pay for his illness or injury, regardless of fault (this is a day of "insurance").

The fifth important point (please do not criticize) was mentioned more often than any other *"don't"*. Your committee feels, with the different members on your state committees, that here is a most important warning. There is not the slightest doubt in anyone's mind who handles malpractice suits, but that this is the cause of a large percentage of cases. If this Council can do anything to prevent unjust criticism, it will have gone a long way in preventing a large per cent of suits. We would go a bit further and say that the court house is a poor place to air even a just criticism.

This Council has rendered a great service to the state societies in taking up for discussion the subject of malpractice. It will tend to create further interstate communication of a constructive nature.

GEORGE E. YOUNG.

Dr. Rowley of Hartford submitted a report from the Committee appointed to consider the paper of Dr. Rushmore presented at the meeting of December 1, 1931 and Dr. Ellingwood followed with recommendations.

REVIEW OF THE PAPER AND DISCUSSIONS AT THE MEETING OF DECEMBER 1, 1931

For a period of between ten and eleven years I was a member and the Secretary of the Connecticut Medical Examining Board and of necessity devoted a good deal of time and thought to matters connected with the topic for discussion at this meeting.

About two years ago I requested that I be relieved from service on the Board, and in that brief period of two years I have become quite rusty on the subject of medical licensure and medical regulations, but Dr. Rushmore's magnificent paper appeals to me in the light of a postgraduate course, and it has been a privilege to read his scholarly paper which brought forth such interesting and general discussion.

It seems to me that Dr. Rushmore, in his closing paragraph, has summed up the situation admirably in saying that the goal of our endeavor in legislation to regulate the practice of medicine, is a just conception of the necessity of such regulation by the state. Adequate provision for intelligent and reasonable control under the domination of that idea is so vital in the wel-

fare of the state that only persons of indubitable fitness to carry the responsibility of the physician should be permitted to enter or continue in the practice of medicine.

We are apt to become exasperated by a lack of a just conception of the necessity for such regulation by the state.

It may require some sort of storm or upheaval or revolution to awaken the public mind to the needs of the situation. We had such an experience in Connecticut just a few years ago, as you all remember, when exposure was made of the bad practices followed in the examinations for licensure by one of our Boards.

The public was then ready to act, but our state laws were inadequate, either for correction or for control of the situation.

Due legislation was enacted which has improved the situation very much in Connecticut, and that leads me to say just a word in behalf of the Basic Science Board.

The Basic Science Board of Connecticut, known officially as the State Board of Healing Arts, works and works well in Connecticut. It gives the people a measure of protection against the dangers of too great a degree of ignorance on the part of those who would practice medicine or something akin to medicine.

The Basic Science Board has been functioning nearly five years, and in that time the naturopaths and the chiropractors have been unable to meet its requirements, and consequently those people have been unable to obtain licenses in Connecticut, inasmuch as the approval of the Basic Science Board is prerequisite to admission to examinations by their own board in order to obtain a license.

The qualifications of applicants can be determined only imperfectly by a written examination, and yet that is about the best means at the disposal of the different boards here in New England where the interne year is not required by the licensing boards.

Dr. Rushmore has developed so clearly the idea of trusteeship in the relationship between physician and patient that I think the Examining Boards might well keep that picture before them when considering applicants on the basis of what is known as reciprocity.

In Connecticut, applicants from other states are considered on the basis of their records as pertains first of all to their education, and, secondly, to their conduct and reputation in the community or in the state in which they have been in practice.

The Connecticut Board feels that the responsibility rests upon it to determine the qualifications of applicants who want to come into Connecticut from other states, and likewise it feels that the responsibility should rest upon the Examining Boards of other states when Connecticut licensees want to obtain a license in those states. While willing to assist in furnishing information about Connecticut licensees, the Board has felt it unwise and possibly unsafe to enter into any agreement with another State Board by which it might be bound in some measure by the actions of that other State Board.

Connecticut accepts licensees from other states but not through reciprocity.

When the Connecticut law was rewritten a few years ago, the Board was given the right to exercise some disciplinary powers over those licensed to practice the regular system of medicine, but no powers whatever over those licensed on the basis of examination by one of the other boards.

Through the exercise of this power, the Board has in the last few years with the coöperation of the Attorney-General's office summoned before it for a hearing quite a large number of physicians to determine whether or not their licenses should be revoked, suspended, or that they be given a warning as to their future conduct.

One cannot be too dogmatic in stating what effect this activity of the Board has had upon those licensed to practice medicine, but it seems reasonable to suppose that it has had some controlling influence in the direction of public benefit.

Those who have violated the prohibition law and have been brought before the Federal authorities for general misuse and sale of prescription privileges, have perhaps constituted the largest group brought before the Examining Board for discipline. The abortionists would probably rank next in number, and almost without exception their licenses have been revoked. Undoubtedly there has been some measure of protection to the public in this, even if the licenses are restored to these people at the next meeting of the State Legislature.

The Connecticut Board is furnished with a copy of the court record whenever a physician is convicted of any crime, whether it be in the State or Federal or City Court. Those convictions furnish the basis of action by the Board.

Under the law, complaints may be made by individuals and if preliminary investigation shows the complaint to have reasonable basis the physician against whom the complaint is registered may be summoned before the Board for a hearing. This is probably a wise provision in the law but one seldom used.

Annual registration of physicians is a wise measure as a part of the state control over the practice of medicine. It is, however, both unwise and unjust for the physicians to pay, through the registration fee, for this measure of safety for the public. We endure it in Connecticut and shall have to until we can bring about some change.

In discussing this topic which Dr. Rushmore has laid before the meeting, I find myself with others inclined to tell of what we do "at home" and that makes it sound somewhat like an experience meeting, but there are a few points I would like to mention for emphasis when Massachusetts undertakes to rewrite its Medical Practice Act. Unless there can be removed the restrictions relating to appointments on the Board and relating to discretion given the Board to determine whether or not a person has had the kind of education that would make him a reasonable candidate for the Board to examine, it might be that the public interest would be served through the operation of a Basic Science Board, which would act as the first filter to which these candidates would be subjected.

Another point: The law should give the Board the power to investigate irregularities of conduct of physicians with the aid of state agencies including the police and the right to exercise disciplinary control, even to the extent of revocation of licenses.

I shall content myself with the expression of these two points as recommendations, and I assume that the others who are to comment on Dr. Rushmore's paper and the discussion, will cover some other points that have for them a special appeal.

ROBERT L. ROWLEY, M.D.

March 9, 1932.

Following the reading of the report there was some discussion.

DR. BLUMER: I would like to say a word about our experience at New Haven, which I referred to at that meeting, because I don't know whether you were all present. We have a committee that hears evidence on malpractice cases. It was rather a new experiment when we first studied the subject. Now when a suit is brought, or even threatened, the man against whom the suit is in prospect notifies the committee, and a meeting of both sides is called. The same is true after a suit is actually begun. Not only the people involved in the suit are heard by the committee, but any doctor who proposes to testify in the suit must appear and since this custom has been in operation (this is the second year), the number of malpractice suits has fallen off enormously. When the committee finishes the hearing, when indicated, a vote is passed to the effect that there was no ground for a malpractice suit, which has been the case in all but one of the complaints which have been heard, and a copy of that vote is sent to both parties in interest.

The State Medical Society has authorized the formation of County committees. Our committee started as a local committee of the New Haven Medical Association, which is not associated, in an organic way, with the State Medical Society, but I am sure the County Societies can now form such committees.

DR. LANMAN: Has the committee any legal power to compel anyone to come before it; what I mean is, if a citizen is asked to appear before the committee is there any legal obligation on his part so to do?

DR. BLUMER: No. In one case which we heard, the plaintiff in the case refused to appear. Of course we could not compel him to come. All who are interested in a given case are requested to come and sometimes they do. We ourselves have even examined the alleged injury and have had x-ray plates taken and have gone into the matter very thoroughly. We allow no lawyers to attend. That rule was made at the beginning.

DR. YOUNG: This is a problem we are mulling over in Maine. Perhaps you could read between the lines in Mr. Locke's paper, especially when he discussed the importance of the Medical Defense Committee and the question of whether he should be left in full charge. Between the lines you could read much of what he thought of having a committee of medical defense. He wished our committee to be changed to an advisory committee. That sounds very well, but you see Mr. Locke is also representing the insurance companies, and there are many cases they don't care to try, but there are a considerable number that we do want to try regardless of the money involved. Mr. Locke has done mighty fine work, but we still feel that it is up to the medical group to say whether they shall defend a man and what cases they shall have tried.

DR. BLUMER: We don't attempt to reach any decision like that. All we decide is whether there really has been malpractice or not. In one case we felt that there was clearly malpractice and we simply closed the hearing. That is all we had to do; the significance of this action was understood.

DR. CALL (President of Maine Medical Association): I would like to say a word in regard to this Medical Defense Committee. It has been very satisfactory in the State of Maine. I was one of the original group, about fifteen or eighteen years ago, who started the movement which has continued up to the present as follows: In each section of the State one doctor was chosen to act as an arbitrator. Whenever a doctor was sued he appealed to the arbitrator in that section (whether in Androscoggin County or the Second, Third or Fourth District), who would go, possibly alone, or perhaps with another physician, to the doctor who had instituted the trouble. As Dr. Young says, the majority of the suits are inaugurated by a doctor who has said something to a patient to the effect that treatments were perhaps not done as they should

have been. The arbitrator would go and talk with that doctor and say, among other things, "Could you have done better yourself? Could you stand up and say to a Court of justice that if you had had this case in the first instance you could have done better than the attending physician?" Well, right away we quashed case after case; of course some cases come to trial but the plan has worked very well on the whole, and many times the lawyer didn't appear. I know that the teeth of the problem, as I see it, are being taken out of it to a degree now that the designation has been changed to Medical Advisory Board instead of Medical Defense Board. I think the method you have, Dr. Blumer, is good.

DR. BLUMER: Don't you think it is the publicity that helps?

DR. CALL: Oh, yes.

DR. BLUMER: When we send in a favorable report it is understood that the Medical Society as a body will stand behind the man sued.

DR. LANMAN: If you found a case where you thought there was malpractice, what would be your procedure?

DR. BLUMER: The only instance where we thought that there was a case we stopped the hearing and the doctors were excused. Dr. Wheeler was presiding at that time, but we didn't put in any report and it was understood that we felt there was a case.

DR. PARKER: What was the effect of that?

DR. BLUMER: The suit went on, as we thought it should.

DR. PARKER: Could they have your evidence for use in court?

DR. BLUMER: Yes; they could subpoena the evidence, if they saw fit.

DR. PARKER: You take written evidence of your hearings?

DR. BLUMER: Yes; we have a stenographer. They have a right to subpoena the evidence in Connecticut.

DR. PARKER: That was brought up in New Hampshire with our Medical Defense Committee; and we decided that no notes were to be taken because they might be subpoenaed.

DR. FULTON: Wouldn't it strengthen your report if you made it in such a case?

DR. BLUMER: I think it had the same effect. We always have given a favorable report, and when we didn't have any favorable report, the conclusion was correctly drawn.

DR. BRYANT: I think the original set of teeth we had in the Maine Defense Committee was pretty good. I am interested to see if the teeth are gradually withdrawn, whether the number of suits will increase or decrease.

DR. CALL: Another thing we had, the doctor testifying in defense of the action could not collect a fee.

DR. BLUMER: That is in our By-Laws; it is not a ruling of the committee.

DR. WILKINS: Our New Hampshire Committee is a Medical Defense Committee, but we at the last meeting of the State Medical Society, changed the name of the Committee to Medical Jurisprudence.

DR. BLUMER: We don't call ours a Defense Committee. I think the technical name is Committee on Medical Ethics and Deportment.

DR. PARKER: Would it be possible for the executive officers of the several States to know what is going on in the other States? For instance, this procedure which you have brought up is very interesting to me.

DR. BLUMER: That was brought out in the discussion at that meeting, but we have had more experience since then.

DR. PARKER: If we had a résumé of what you are doing, what we are doing in New Hampshire and what they are doing in Maine, I think it would be of value as it would give us a record of good results obtained in other States and might be a basis on which we might work out something better still.

DR. YOUNG: That is what I tried to bring out. I thought the report of the last meeting would stimulate action between the different committees, because there would always be something that one state can take from the other if our different departments and boards would communicate in some ways with each other.

DR. PARKER: I think there ought to be some medium of exchange.

DR. WILKINS: Would it be a practical thing to have a résumé prepared which would state the methods in vogue in each separate State, and have that put into pamphlet form?

DR. BLUMER: I don't see why it wouldn't.

DR. PARKER: I question the advisability of putting it in the Medical Journal, but it could be sent as a private communication to the officers of the various Medical Defense Committees. Would that be possible, Dr. Bowers?

DR. BOWERS: Yes, that would be possible, if you would have somebody besides the Secretary do it.

DR. WILKINS: Why couldn't the Secretary of each Society which is carrying on this work prepare a résumé of the way it is carried out in each individual State and send it to Dr. Bowers?

DR. BLUMER: Would you make that in the form of a motion?

DR. WILKINS: Yes, I would make that as a motion.

DR. PARKER: I second that; with the understanding that it is not to be public property.

The motion was carried by vote.

DR. BOWERS: The Secretary of the Council will write to the Secretaries of the different State Societies and get them to prepare a résumé of their proceedings in such matters and then send the complete account of the proceedings in each State to the Secretaries of the different State Boards. Is that the idea?

DR. BLUMER: Yes.

Upon motion duly seconded, it was

Voted: That the report be accepted and the recommendations adopted.

Further Voted: That the recommendations be referred to the Executive Committee for full consideration and action.

Meeting adjourned at 6.50.

Following dinner at the Harvard Club, the meeting was reconvened at 8:15 in John Ware Hall.

DR. BLUMER: *Ladies and Gentlemen*—This meeting was arranged by the New England Medical Council. It is the first public meeting that we have held. This body has been in existence for several years but heretofore the meetings have been confined to members of the Council and invited guests. It has seemed to us that it might be worth while to try the experiment of having a public meeting inasmuch as the question of medical publicity has been before the public so much of late.

We have asked Dr. Iago Galdston, Executive Secretary of the Medical Information Bureau of the New York Academy of Medicine, and Dr. Morris Fishbein, Editor of the *Journal of the American Medical Association*, to come here as our guests this evening; and I am happy to introduce as the first speaker of the evening Dr. Galdston.

MEDICAL PUBLICITY BY ORGANIZATIONS AND INDIVIDUAL PHYSICIANS*

BY IAGO GALDSTON, M.D.†

Mr. Chairman, Ladies and Gentlemen: The title of my paper as dictated by Dr. Bowers is Medical Publicity by Organizations and Individual Physicians. They say that a good paper ought to contain both wit and brevity, but I am not in position to guarantee either of the two.

IT has been said with justification that the disputations of man more frequently arise out of a divergence of understanding than out of a disagreement on ideas. More tersely, we have been taught that definition is the soul of argumentation.

The subject of medical publicity is a provocative one. Lest we fall into disagreement because, though using the same words, we endow them with different meanings, let us commence by defining what we mean by publicity. Our definition should not be of the dictionary character, but rather in accordance with the meaning given by common experience.

Webster defines publicity as "the quality or state of being public or open to the knowledge or observation of the community". He further defines publicity as "equivalent to notoriety and to publicness, as the publicity of a scandal".

It is in this latter sense that we see publicity operating in American life. In our experience publicity is really a synonym for ballyhoo and our native pioneer exponent of publicity was Barnum, whose fundamental credo was "There is a new sucker born every minute." Even professional publicity persons eschew the term publicity as one might the tar brush. They become "public relations counsels", strongly disavowing all that publicity implies.

Needless to say, neither medical organizations nor individual physicians can morally afford to indulge in publicity. For the sake of complete escape from this pestilential plague, we should assiduously avoid the term publicity. Let us recall the wise old adage, "Give a dog a bad name and you might as well hang him."

Call it what you will, however, there is a relationship which medicine and society owe to each other, a relationship in which medicine must become articulate, and it is this relationship that we are to consider tonight. I make this statement baldly, and yet I am not willing that it should be taken for granted. I desire rather that we should subject it to critical analysis, and seek to establish the origin and necessity for the advised relationship.

For certitude on this score, we must turn to current history, to the events which you and I have witnessed. History then teaches us that the days when medicine, like the priesthood, was a profession apart and above the rest of the community, are gone. Our profession is ruled and legislated by the common lawmakers. We are scrutinized and catechized from the day we enroll for our medical studies to the time we graduate and enter our practice. We must enroll with the clerk of our community and in certain states every year thereafter, and may it be added parenthetically, there is a fee charged for every registration. The very practice of our

*Address before the New England Medical Council at its meeting, March 10, 1932, at the Boston Medical Library.

†Galdston—Executive Secretary, Medical Information Bureau, New York Academy of Medicine. For record and address of author see "This Week's Issue," page 1372.

profession is legislated, so that the spiritus frumenti which we may prescribe for our patients is dictated not by medical experience but by laws written in Washington. We are bound by a silver cord to the navel of society, though at times it would appear as though the other end were wound around our necks.

We have lost our old position in other ways, too. The public no longer regards us as sanctified. They speak of us not with bated but with heated breath. I call in witness the numerous articles which have appeared in the public press, in which laymen have scourged our profession, charging us with all the multitudinous sins of the modern age. We have been driven from the honored and revered estate of former years to where we have to fight for our very existence as free individuals practicing an ancient profession. We are confronted with a multiform competition. Philanthropists more concerned with the remedy of immediate wants than with the ultimate solution of knotty problems, are setting up clinics, hospitals, health centers and what-nots, in which we are to serve as hired agents. There is much talk of state medicine, health insurance, and of various and sundry schemes in which the medical profession appears to be a pawn in the hands of alien players.

And in the midst of this stands the giant, the medical profession, tongue-tied, if not completely inarticulate. I present this picture to you as warrant for my cardinal thesis. Perhaps you would charge that I paint this picture with too free a stroke and too harsh a contrast in lights and shadows. If I am charged with exaggeration, I am willing to plead guilty, knowing full well that every protagonist is inclined to exaggerate; but I maintain that the exaggeration lies only in the contrast of lights and shadows, and not in the substance of the picture drawn.

Viewing the matter in this light, one is readily overcome by a sense of pessimism. In one's ears there rings the lamentation, "Woe is us, we are fallen upon evil days." I for one do not share this pessimism. On the contrary, I see in the situation the light of hope. I maintain that as a profession we are not being abused but merely challenged. We may look nostalgically to yesterday, to the homely time when the family physician was a specialist in everything, a friend and a confidant of many families in his community. We may reflect upon this period with the same sentimentality that we recall mother's cooking. But confronted with a frank choice, who among us would willingly return to the pomposities of yesterday? I feel that in the present situation there is a challenge to be met, a justification to be found and an adjustment to be made. Society has a right to place us on the witness stand and to examine and cross-examine us. To meet this challenge successfully, we need an articulate voice and an integrated intelligence behind it, and may I add parenthetically, that the voice comes first.

The greatness of Athens was not in the Acropolis, but in its market place, the amphitheatre of Socrates and the university of the Athenian. It was there that men foregathered to exchange thoughts, to listen to the gadfly questionings of the bald-pated philosopher and to swap experiences on various Hippocratic practitioners.

We live today in a greater Athens, in which there is a bigger market place, and our voice should be heard in the babble of the populace, not only that we might defend ourselves against calumny and set men aright in their judgment of us, but that we might also serve the community by bringing to it that knowledge which will serve better and longer life.

The American public has an insatiable curiosity, and curiosity is the fertile muck in which the rare flower of intelligence flourishes. The public demands, as is its prerogative, to know what is going on in the community, in medicine as in politics. When the King of Siam comes to America to be operated upon, there arise in the public mind a hundred questions, most of which are legitimate and not a few of which are intelligent and useful. When, by the artifices of the publicist journalists, a sensation is created in the alleged "one chance in a million" of success of a certain operation, we are duty bound to enlighten the public and to prick this malicious and fanciful bubble. When a spectacular announcement is made that a cure for cancer has been discovered on the Pacific coast, can we blame the public for its clamor to be informed? Can we afford to fail in the duty to ourselves and to the public that demands information by enveloping ourselves with the mouldy cloak of dignified silence? When the committee studying the costs of medical care has a report to make, shall we confine the illuminating facts which they discovered to within the sphere of the profession, or should we "let the public in"?

These are but a few instances taken at random from our current experience, but they illustrate the compelling necessity for developing an articulate relationship between medicine and society. How can this be done? The precise method must vary from place to place as the circumstances differ. In New York City we have a Bureau with an executive staff devoting all of its time to the dissemination of medical information. That this information might be authentic and representative of the consensus of opinion in the medical profession, there is a supervising Executive Committee which is constantly in touch with the executive staff. Since we are called on for a wide variety of facts and information, we have associated with the Medical Information Bureau a consultant group of

more than one hundred physicians representing all of the medical specialties.

The credo of the Medical Information Bureau was set down in the following words:

"From its earliest days the profession of medicine has been governed by a code of ethics which has served to maintain the lofty ideals of the followers of Aesculapius. Unhappily, this code has also served to insulate the profession against intimate contact with the public.

"Whatever may have been the forces and motives that moved the early law makers of medicine to instill an element of secrecy and aloofness into the governing principles of the profession, certain it is that the best interests of the physician and of the public are no longer served by this attitude. The recent and phenomenal progress of modern medicine, and particularly of preventive medicine, necessitates the development of a direct and intimate channel of communication between the practitioner and the community. This is essential, not only that the public may learn to take advantage of the constant advances of modern medicine, but to the end that it may be protected against the hordes of charlatans, quacks and misguided zealots who, strange to say, thrive more than ever in this day of presumptive enlightenment.

"In appreciation of the needs of our day and society, the New York Academy of Medicine and the Medical Society of the County of New York have established a joint Medical Information Bureau. The aims of this Bureau are to facilitate the dissemination of authentic information on medical and public health matters, to stem and curtail quackery and to promote a better understanding between the public and organized medicine.

"The Medical Information Bureau is supervised by a Committee representing equally the Academy and the County Society. It is served by a body of over one hundred consultants competent to give expert opinion on a variety of questions relating to their specialties. The full resources in judgment, knowledge and experience of the medical profession in New York are 'on tap' to aid its purpose."

The Medical Information Bureau has been in operation now three and one-half years. It has been eminently successful in achieving its objectives. It has secured the good will and coöperation of the press, the radio broadcasting stations and certain other agencies which carry news and information of a medical nature. It has succeeded in presenting to the public through the press important scientific papers presented at the New York Academy of Medicine, and to give notice of various discussions of a social nature. It has assisted newspapers in checking on the authenticity of news items which they have received from various parts of the world, and it has helped them in the preparation of feature articles of a medical nature.

The Medical Information Bureau has not, however, and this is important, set itself up as censor. It has not sought for publicity, in its undesirable phases, for any of the activities of the individual physicians connected with the New York Academy of Medicine or the Medical Society of the County of New York, nor has it publicized these organizations.

Lastly, it has never aggressively promoted medical news. It has released to the press and other news agencies the medical information available, leaving it to them to decide whether or not that made news.

DR. BLUMER: It gives me pleasure to present as the next speaker Dr. Fishbein.

MEDICAL PUBLICITY AND ADVERTISING*

BY MORRIS FISHBEIN, M.D.†

I AGREE with what Dr. Galdston has told you and I believe he is doing a magnificent work in New York. Every state capable of getting somebody as good as he is in this work and as capable of carrying it is to be congratulated. He issues scientific news and he does not promote individuals. He is truly the public relations counsel for the New York Academy of Medicine. In the work of the public relations counsel lies a tremendous power. When he takes that power seriously and does what he can for the dissemination of good medical information, he is a good public relations counsel.

Percival, at the beginning of the 19th century, proposed a code of ethics and that code of ethics was adopted by the American Medical Association about 1847. That code has been continued almost without change. The code of ethics said that the solicitation of patients by physicians through publication of advertisements by whatever name this be called, by institutions or organizations, whether by circulars or advertisements or personal communication is unprofessional. This does not prohibit ethical institutions from calling attention to the location of an institute where teaching of physicians is conducted. "It is equally unethical," says the code, "to appear to solicit patients through indirect advertising or by furnishing information, by inspired articles in the newspapers or magazines carrying comments concerning cases in which the physician has been and is concerned."

Now consider the case of the King of Siam who came to this country for an operation on his

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†Fishbein—Editor, *Journal of the American Medical Association*. For record and address of author see "This Week's Issue," page 1372.

eyes and of the physician in New York who took care of him. Make up your mind, if it were up to you,—if you were in Dr. Galdston's position, —whether or not you would release any publicity about this physician. Would you tell the newspapermen to go ahead or to stop? Frankly, no public relations counsel I know of would have the ability to stop a newspaper from printing anything the paper wanted to print in this case. Few, if any, newspaper editors ask whether they should print anything they have decided to print. If an editor is any kind of an editor at all he doesn't ask anybody; he makes his decision on the evidence, goes ahead, and takes the consequences. If he happens to be wrong very frequently, he is soon no longer an editor. If he happens to be right in the majority of cases he is called a person of great judgment and acumen and he wins success in his chosen field.

The simple statement quoted from the Principles of Ethics, which anybody can interpret, continues to be the principle that actuates the American Medical Association in all questions of publicity. It actuates Dr. Galdston in his judgments acting for the New York Academy of Medicine. This principle guides practically everyone controlling opinions as to medical publicity as to how he shall advise those people who give out medical publicity through the newspapers, the magazines and over the radio.

This was not a tremendously important clause in medical ethics in the past. The story of modern advertising begins with the twentieth century. Before that there used to be an occasional physician who got out a health book to hand to his patients, and there would be men who thought that was a method of soliciting patients. Occasionally in some foreign neighborhood there would be a man who would publish in the papers a little card announcing that he spoke the language. That was probably advertising, but it did not disturb anybody much. At the beginning of the twentieth century, big business came into the picture. Organizations developed in medicine not only of the type of a few individual physicians joined together in groups in certain sections, such as the Mayo Clinic, but also great university medical clinics. Before that time there were no centers such as the Baker Foundation, the Cornell Clinic and other centers of that character. Then we began to be concerned with an important question,— whether or not five or six physicians or fifteen or four hundred organized as a group are entitled to privileges in respect to the public to which an individual physician is not entitled. The question is important to the physician, because a group of physicians organized in a hospital or a community have powers financially and socially above those of the individual. It is recognized as sound that an individual physician should not buy advertising space in newspapers. If this is done the physician who has the most money can buy the biggest space and thereby get the most practice as long as he continues to buy space. Anybody that spends money for the exploitation of himself by notices in newspapers, magazines and over the radio, can bring himself practice probably beyond his actual merits.

An osteopath, Curtis Muncie, developed what he called "finger surgery" for deafness. He sticks his finger down the throat and up in back of the nose. He claims thus to enlarge the eustachian tube and this he claims will cure progressive hardness of hearing. Curtis Muncie did not buy much advertising space. Probably he could not have done so. He did employ a public relations counsel. In the fertile mind of that counsel arose the story that Curtis Muncie had cured the son of the King of Spain of deafness by this marvelous discovery. The story appeared in the magazine sections of the Hearst papers. Curtis Muncie began to profit; great sums of money came into his hands. A patient who wanted to see him had to wait eight or ten days to get an appointment. This came merely through the publicity.

Norman Baker, cancer quack of Muscatine, Iowa, claimed that cancer was conquered. He used the Ozias and Hoxie "cancer cures". He opened a cancer institute and exploited himself over a radio station through a license given by the Federal Commission. He testified on the witness stand recently in a trial in Davenport that the first money earned was $1300 a month and within two years he was getting $75,000 a month by the business developed through radio exploitation. Then the American Medical Association published some facts and brought them to the attention of the Federal Radio Commission. The commission took away his license to broadcast and his income began to drop. In December, 1931, it was only $7000 a month— which is a fairly good income yet. It seems quite likely, since the courts have decided that the American Medical Association told the truth when it said he was a quack and fakir, that the practice of Norman Baker will continue to diminish. Publicity made him and it was publicity that could break him.

Bear in mind that publicity need not be purchased advertising space. Many believe it is the duty of scientific medicine to advertise, not only in order to bring increased income, but because vast numbers of people do not know the difference between scientific medicine and the practice of quacks and charlatans and fakirs. They feel that in addition to taking care of patients without fees it is the duty of physicians and nurses to find poor people and to induce them to take scientific treatment. In other words, they wish to place an additional burden on scientific medicine. Quite recently I discussed this subject with Bruce Barton, directing head of a great advertising agency. He said the Ameri-

can Medical Association ought to spend money to buy advertising space in order to tell the public what scientific medicine is. Any advertising agency will help you spend money for the usual commission. Of course, the advertising agency sees to it that your money is distributed in proper places.

Fortunately the public is no longer at a loss for health education. The American Medical Association has a Bureau of Health and Public Instruction. This bureau distributes pamphlets, broadcasts over the radio and has other means of reaching the public. There are in the United States today approximately fifteen men who write daily health columns for the newspapers. Dr. Galdston writes a column distributed through the Associated Press feature service. W. A. Evans writes a column through the *Chicago Tribune* Syndicate, James Barton writes an article distributed through another syndicate. Royal Copeland, also a senator, broadcasts and writes a daily column distributed through the Hearst syndicates. Dr. William Brady and Logan Clendening are syndicated and I write through the N. E. A. Service. The public is perhaps overfed with health education; it is being informed in regard to the benefits of public health and scientific medicine through the medium familiar to all, the daily newspapers. It is important that the daily newspapers have realized the value of health education to the public in relation to disease and disease prevention and have seen fit to buy material of that character.

I emphasize the point particularly because there seems to have grown up an idea that curative medicine must be paid for but that preventive medicine should be free. When a newspaper wants to run a daily column on contract bridge it engages a prominent exponent of the game to give instruction as to his system and it pays his price. There is no refund if he does not know the game. When the baseball season is on, experts write columns about the game and get paid for them. Why should a man who writes on the prevention of disease and the nature of disease contribute that education for nothing? Newspaper editors have realized that material well written and instructive is worth paying for in medical as in other fields.

Concerning education over the radio and on the lecture platform, the British Medical Association saw this trend early and wanted the best men in England to go about and give lectures. In their code of ethics a statement appears to the effect that physicians may go about and give instruction. The suggestion is carried that such education is a commodity that the public should have, and that the physician is well within his rights to receive a fee for a lecture to be given in the interests of public health. Notwithstanding there are vast numbers of people who believe that lectures ought to be given by a physician without any payment for his time or his service. It is urged that public health lectures be given in as anonymous a manner as possible. One should not advertise that a doctor is coming to give the lecture because people will know in this way that there is such a doctor. Some claim it is unethical to say that the speaker is an authority on pneumonia, for instance. They say that when a physician speaks over the radio he should be known as our unknown guest or the mysterious stranger. They feel it is not good for the public to know the doctor who has spoken on this subject over the radio, because he will have an advantage above that of others in the profession. There is nothing in the ethics of the profession that says a physician shall not lecture. In fact, some fifteen years ago there was written into the Principles of Ethics a statement that it is the duty of the physician to educate the public in matters of health and to use every legitimate and ethical means possible to carry public health education to the people.

Publicity may be, and has been, definitely abused, not only by charlatans and quacks, but by some members of our profession. Groups organized to practice medicine for profit, great university clinics organized to practice medicine, hospitals and centers, and demonstrations have frequently aroused serious concern. Unfair competition in trade is frowned upon. Similar conditions may arise in the field of medicine. Rules may be applied to group practice exactly as they are applied to the individual physician. Consider the size to which a university clinic may grow. A university is obviously in the business of teaching physicians and preparing them to go out and practice. It is therefore unfair to allow it to grow to such an extent that it competes too greatly with the practice of the men it puts into the community. It is safe to say that the maximum size of a university clinic should be the number of beds necessary for teaching purposes. The primary purpose of the university is to teach medicine and not necessarily to take care of sick people in the community. It is safer for the public if an individual physician takes the responsibility for the patient,—much safer than when the responsibility is laid on a group, a corporation or a clinic. An individual physician cannot call himself in an undue manner to the attention of the public. He cannot employ a public relations counsel to bring him to the attention of the people in the community. For the same reason the university, which practices that it may teach the physician, should not be permitted to call itself in an undue manner to the attention of the people or cause people to go to the clinic rather than to their individual physicians. All of us know, however, of various clinics that have called themselves unduly to the attention of the public. There are several university hospitals in the United States which are apparently un-

limited in growth — that continue to add hundreds and hundreds of beds year after year, so that they seem to be planning to take over almost entirely the practice in the communities in which they are located.

The question has been raised as to whether or not the teaching of medicine should be carried on exclusively with charity patients. In some places it may not be possible to obtain charity patients of such type as to constitute adequate teaching material for scientific medicine. Endowments are not always sufficient for necessary clinics. Teaching institutions must naturally see to it that certain amounts of income from the patients go to the conduct of the institution. Otherwise, all medical schools must come eventually under endowments and thereby be forced to make arrangements for teaching and practice dictated by the group from which they obtain their funds.

Consider next the demonstrations in child care in health centers. Here again is an interesting point which many have overlooked. Administrators have adopted the view that adults should be considered as individuals but that children may be handled in mass lots of 50 or 1000 or 5000. That is a strange notion. The child is just as much an individual as an adult. The subject enters into this consideration because the primary purpose of the demonstration is health education. There has never been a demonstration but what there has been associated a tremendous amount of publicity including advertising by pamphlets and posters urging mothers to bring their children to the clinic or the center, regardless of ability to consult a private physician. Here, obviously, is unfair competition with the physicians of the community.

In several large cities recently there have been campaigns for inoculating the child against diphtheria by the use of toxin-antitoxin and toxoid. Pamphlets and posters are given out urging mothers to have their children given the proper inoculation. The appeal says: "See your family physician and ascertain whether he thinks your child should be vaccinated; and if he doesn't undertake to do it, bring your child to the health department." How does that work out in practice? The mother calls up the family doctor and says, "I have a letter here which says I ought to have the baby inoculated to keep him from having diphtheria. Is that all right?" The doctor says, "Yes." She says, "Can you do that?" He says, "I can." She says, "Do you use the same method they do at the health office?" He says, "I do; it is a well-recognized method and your child is suitable for the inoculation." "Well, doctor," she asks, "if I bring the baby to you, how much will it cost?" He says $5 or $3 or $2 or whatever he thinks it ought to cost. Then she says, "What do they charge down at the health department?" He says, "They don't make any charge; that is supported by the county." "Well," she says, "wouldn't I be a sucker to pay you $5 when I can go to the health department and get the same thing for nothing?" If he is an honest doctor he urges her to go and have it done, and done free, because the baby ought to have it. The point, particularly in a time of economic depression, may well give the physician concern. Here is the health department, actually competing with the doctor, using direct-by-mail advertising, solicitation by visiting nurses, calls over the telephone, and other ways that modern publicity employs.

There are all sorts of means of education of the public in matters of health. There are right ways and wrong ways to say almost anything to or about anybody. The editor of the *Chicago Daily News* wrote an essay entitled, "It Is the Way It Is Written." This applies especially to publicity for scientific medicine.

I show now a few lantern slides of samples of paid advertising.

(Slides shown and discussed.)

We are all agreed that every medical organization ought to give publicity serious consideration. How is it to be done and what limitations are to be placed upon it? Dr. Galdston and his bureau in New York have done an excellent job in the investigation and censorship of medical information. Other communities might well follow their ideas. I want to comment, however, on one phrase he used: "The medical profession has been driven into this picture." Actually the medical profession has not been driven. It has used the leadership available in this work. I could describe at considerable length the ways in which the American Medical Association coöperates with the Associated Press, the United Press, the International News Service and other news agencies of different types. I could tell anecdote after anecdote concerning incidents in which the people have been protected by enlightened publicity, and others concerning people who were led away from their family physicians and drawn into the clutches of advertising quacks. Through the headquarters office, leadership for controlled health education and publicity has been exercised for at least ten years.

Several years ago a great advertising agency brought to the headquarters office for examination a series of advertisements to be paid for by one of the great medical supply houses and to be published in leading periodicals throughout the country. The advertisements shown in the slides are simply educational statements as to the value of various procedures used by scientific medicine, and also a statement as to the education of a modern physician. After the copy for these advertisements had been suitably

edited in the headquarters office of the Association, the series was published in many leading magazines. Coincidently with the publication of this series, other organizations which depend on the good will of scientific medicine for increasing sales of their products began similar campaigns. Such campaigns have now been published by Parke Davis & Company, Squibb's, Merck, Mead Johnson, Metropolitan Life Insurance Company, the American Bakers' Association and similar groups. This is, of course, quite legitimate. Unquestionably much may be accomplished if the firms which depend on good will of medicine for their own existence and for their advancement will see to it that the public is properly informed concerning what scientific medicine can do.

In every instance these firms have brought their advertising campaigns to the Association for reading and approval, and in most instances the campaigns have appeared also in *Hygeia, the Health Magazine*, published by the Association. While it is hardly to be expected that physicians will themselves pay for promoting their cause through newspapers and magazines it is strictly within the realm of business ethics for these allied firms to carry out the campaigns that they have published.

In a few instances county medical societies and, in some instances, state medical organizations have embarked on advertising campaigns of a similar character. In some cases county medical societies and state medical organizations have published the names of regular members of the organization in newspaper announcements. Thus far evidence is wholly lacking that such campaigns have been of benefit to the public health and quite certainly they have not paid their way financially in increased returns to the physicians who paid for the space.

Our modern age has learned to use publicity as a powerful weapon. Propaganda for anything will succeed temporarily, but if it is opposed to fundamental human instincts or if it is untrue the facts become known and the repercussions are serious. In all the campaigns for carrying preventive medicine to the public which we in the headquarters of the American Medical Association have supervised, we have insisted on limitation to those methods which were fully established as efficient and harmless. The results have been favorable and there have been no serious repercussions.

Propaganda is a most potent force, used today to control practically every phase of human thought and action. Medicine has but trifled in its employment, whereas the possibilities of more extensive and proper use of established technics might yield great good to the advancement of medical science, the good of the medical practitioner, and, above all, the health of the public. The philanthropies in the field of medicine, the corporations engaging in medical practice, are using propaganda far more efficiently than it is used by organized medicine. Indeed, the old inhibitions are strong and organized medicine has not yet determined how far it wishes to go in opposing unsound propaganda in the field of social medicine with its own point of view. The choice must nevertheless be made. The opinion of the public is being established for it by teachers who have studied the situation and who realize how the opinion of the public is formed. If the medical profession is to have any part in controlling public opinion, it must accommodate itself to the situation and use the forces that are being mustered by the opposition. Through the publication of its own health magazine, through its contacts with the press, through its association with the great commercial interests allied to medical practice, through coöperation with many social services and philanthropies of high leadership, organized medicine is beginning to avail itself of the powers of propaganda for its own and for the public good. But the situation demands far more consideration by organized medicine than it has yet had.

DR. BLUMER: I will ask Dr. Roger Lee to continue the discussion.

DR. LEE: *Mr. President*—I am sure that I speak for all of you here in saying how much we have enjoyed these two addresses. I think they have both furnished a great deal of food for thought. The only thing one from this community can say is that we have listened, we have admired, and that we hope sometime to go and do likewise. We can't expect to do so well as these two men have done. I would like to point out to you that these two men have opened up a new specialty in medicine. I have previously thought that perhaps we weren't going to have any new specialties in medicine. I am not quite sure what they call this specialty. We don't like the word "publicity" and the term "public relations" is a very hard one. But I think we can look upon these men as medical publicists, men who interpret the doctors to the public. They are doing decidedly more than that because I think we must appreciate the fact that they are also interpreting the public to the medical profession. These men are pioneers in a new field for, as Dr. Fishbein says, this is all new since 1905. If we go a little bit further back, we can remember when all the medical and scientific works were written in Latin because of the fear that if they were written in the vulgate they might fall into the hands of the laity. We have gone a long way from that. But it is only within the last few years that men have appeared who are specialists in this particular field, who are interpreting the medical profession to the public and the public to the medical profession.

And I would like to say, in conclusion, just one other thing. I think probably the greatest service these men are doing is that they are interpreting the medical profession to itself.

DR. BLUMER: I will ask Dr. Charles F. Wilinsky to continue the discussion.

DR. WILINSKY: As I listened this evening to Dr. Fishbein's recital of the quackery and the unethical and vicious medical advertising emanating from Chicago and its environs, both my sympathy and admiration for him have increased because of a profound appreciation of the terrific conditions under which he labors and dwells. I wonder, too, how Chicago can spare him at all to the rest of the country when he appears to be needed there constantly for the exertion of his influence in the control of vicious propaganda issuing from that locality.

I reëcho the sentiment expressed by Dr. Lee of our appreciation of the subjects called to our attention this evening, which are of such vital interest to the medical profession. It is refreshing to find that there are plans and methods whereby scientific medicine may ethically and soundly present to the public certain knowledge and certain conclusions which may be of aid in guiding the layman in his quest for all that is best in the art and science of medicine.

I am just a little bit perturbed and confused, however, because of Dr. Fishbein's allusion to fairly typical literature distributed by Health Departments, stressing, for example, that the mother shall bring her baby to the family physician or to the organized clinic. I am sure that Dr. Fishbein endorses any effort which will encourage the intelligent mother to bring her baby to her family physician for immunization against diphtheria, vaccination against smallpox, for periodic examinations, etc. However, if for any reason she will not bring her child to the family doctor, we trust that Dr. Fishbein, for the best interests of public health as a whole, is sympathetic to our suggestion and hope that mothers will be encouraged to bring their youngsters to preventive clinics. I am sure that Dr. Fishbein agrees and appreciates the fact that those of us who are entrusted with certain responsibilities in the field of public health have definite obligations to perform in the direction of disease prevention and health promotion, and that while we look forward eagerly to the time when intelligent people will go to their own family physicians for various preventive services, we are obliged in the meantime to promote certain specific services of ultimate benefit, we believe, in the long run to the medical profession. Some of us address medical societies in Boston and elsewhere from time to time and are challenged often with the statement that nurses of Departments of Health are almost bodily forcing mothers and children to attend infant and preschool age clinics. On such occasions we can only stress our sincere belief that real assistance in this direction must come from the ranks of the medical profession whose members are justified in ethically promoting publicity of the fact that they are qualified and willing to do this work in their own offices. We cannot help but genuinely regret any feeling on the part of physicians that local health clinics maintained by the municipality are in any sense of the word competitive organizations of the medical profession, particularly since we never lose sight of the important fact that the physician is the most important and always will continue to be the most important individual in any plan for the prevention or treatment of disease. We realize too well that only when the rank and file of the medical profession begin to practice preventive medicine will we be able to provide public health adequately to the 120,000,000 inhabitants of the United States. All of us interested in the public health movement hope and pray that the time is rapidly approaching when the attendance in our infant, preschool, tuberculosis, and other clinics as well as health activities will be decreased because of the gravitation of people in increasing numbers to the offices of the family physician.

I am grateful, indeed, for the contributions made this evening by Dr. Galdston and Dr. Fishbein which I trust will encourage the members of the local medical profession in the direction of greater ethical publicity. Dr. Galdston has presented to us very splendidly the program of publicity fostered and carried on by the New York Academy of Medicine under his able direction, and Dr. Fishbein has not only shown us unethical publicity and its effect upon the laity, but I am sure, justified certain procedures to be available to the medical profession which would do much, if carried on in sufficient measure, to promote health, prevent disease and cure the sick.

CASE RECORDS
of the
MASSACHUSETTS GENERAL HOSPITAL

ANTE-MORTEM AND POST-MORTEM RECORDS AS USED IN WEEKLY CLINICAL-PATHOLOGIC EXERCISES

EDITED BY RICHARD C. CABOT, M.D.
F. M. PAINTER, A.B., ASSISTANT EDITOR

CASE 18261

HEMATURIA AND COMA IN A MAN OF FIFTY-FIVE

MEDICAL DEPARTMENT

PRESENTATION OF CASE

DR. ALFRED O. LUDWIG*: This is the case of a fifty-five year old Swedish baker who was in the hospital three times.

First admission. When he was first seen six months before his third entry he complained of weakness of six months' duration, some shortness of breath of four months', and swelling of the ankles of five weeks' duration.

He had a past history of long use of small amounts of alcohol.

Physical examination showed a pale man. The heart was slightly enlarged. He had a slight systolic murmur at the apex. The liver was down three or four fingerbreadths below the costal margin. The spleen was palpable. There was pitting edema of the ankles.

At that time he ran a low grade fever to 100°, at one time up to 102°.

He had secondary anemia, a hemoglobin of 45 per cent, a red blood cell count of 3,000,000 and 2,000,000, a smear roughly normal, 64 per cent polynuclears, white cell count 7,500. The urine was negative except that a concentration test showed inability to concentrate above 1.011. The renal function was 50 per cent. At that time the non-protein nitrogen was 27 milligrams per 100 cubic centimeters. A liver function test showed 30 per cent retention. The icteric index was 15 to 20. A van den Bergh was 2.6 milligrams.

He was treated with intravenous glucose, with theocin and salyrgan, and was discharged in about ten days much improved.

History of interval. He took diuretics at home, worked daily and felt well for a while. Two months before his second entry he had nocturia twice at night. For two weeks before his reëntry he noted gradual swelling of the scrotum, and his urine was red. The scrotum was tapped in the Outpatient Department the day before he reëntered and hydrocele fluid was removed. A cystoscopy was done. There was considerable bleeding. The prostate was enlarged, producing a tight bladder neck. The bleeding appeared to come from that region. The Genito-urinary Department referred him to the wards on that basis. He reëntered the hospital because he was passing gross clots of blood at that time.

Second admission, four months and a half after his discharge.

Physical examination showed him to be somewhat obese, with numerous telangiectases of the skin. The sclerae and skin were subicteric. The left eye had been enucleated. A systolic murmur was heard loudest in the second left interspace. The blood pressure was 160/100. The abdomen showed a ring of small dilated venules all along the costal margin. The liver edge was again palpable four fingerbreadths below the costal margin. There was pitting edema of the legs, thighs and sacrum, also of the scrotum, and some fluid in the scrotal sac. There was a slight amount of bloody urethral discharge.

The urine showed a large trace of albumin and was grossly bloody at the first examination, just after the cystoscopy in the Outpatient Department. On the second occasion there was a small trace of albumin and the sediment was loaded with red blood cells. The specific gravity was 1.018 to 1.015. Blood examination showed 70 to 55 per cent hemoglobin, red cell count 3,000,000, white cell count 6,000. A liver function test showed 25 per cent retention. The icteric index was 15. The van den Bergh was 3.45 milligrams, slightly increased.

He was again treated with diuretics—salyrgan and ammonium nitrate—and a low carbohydrate diet. He was discharged at the end of twelve days.

History of interval. He went home and did fairly well for three days, though he was mentally somewhat confused. Then he began to fail rapidly. He had irregular respiration, lower abdominal pain and nausea though no vomiting. He became semistuporous two days before the last entry. He was sent in by his doctor with a diagnosis of uremia.

Third admission, six days after his second discharge.

Physical examination was as it had been before with the following exceptions. He was semistuporous, hardly able to understand, and responded with great difficulty. His breath had a peculiar musty, sweetish odor. His heart was normal. The liver, which had been four fingerbreadths below the costal margin at the examination two weeks before, was no longer palpable, and no liver dullness was percussable below the costal margin. There was marked tenderness in the right upper quadrant, also in both costovertebral regions, more on the right. The reflexes were all increased. There was facial asymmetry and slight right facial weakness. There was generalized twitching all over the body.

The urine showed a very slight trace of albumin. It was loaded with white blood cells, and there were occasional red cells.

Our impression on entry was portal cirrhosis

*Recently senior interne on the East Medical service.

with superimposed acute yellow atrophy and anemia. At that time we did not think he was uremic. We had not then done any chemistry studies. He was obviously moribund. He was treated with constant intravenous glucose infusion. Blood chemistry studies showed a non-protein nitrogen of 75 and a carbon dioxide combining power of 45.8 milligrams. A liver function test showed 5 per cent retention. A van den Bergh was 1.5 to 2 milligrams, distinctly lower than it had been before. The liver function test was repeated that same day and showed 35 per cent retention. The icteric index was 15.

The twitching and breathlessness were controlled with intravenous dextrose and luminal. Two days later the urea nitrogen had risen to 28, the uric acid to 4.3. Another liver function test showed 60 per cent retention with an icteric index of 25 and a van den Bergh of 3.6. He had one more series of blood chemistry studies three days later. At that time the non-protein nitrogen was 105, the blood urea nitrogen 55, the carbon dioxide combining power 44.9.

We thought at that time that he was developing an acute nephritis, which has been described as secondary to cases of acute yellow atrophy, and that his rising non-protein nitrogen was possibly due to this. At this entry the urine after the first specimen showed a very slight trace of albumin, a specific gravity of 1.012 and 1.008, 60 to 80 red cells in one specimen, occasional red cells in the other, and a large number of white cells both times. Blood studies were apparently the same as before, hemoglobin 60 to 65 per cent, 3,000,000 red cells.

At one time six days after he came in we thought we felt the liver again below the costal margin. We interpreted that as due to some regeneration. About two days before death his lungs began to fill up with râles on both sides. We thought that he had bronchopneumonia. A week after admission he died.

Clinical Discussion

Dr. Richard F. O'Neil: I do not think the prostatic picture had much to do with the condition. When he first came in with a low non-protein nitrogen it did seem as if there might be some back pressure from the prostate with varying amounts of albumin in the urine. We put him on constant drainage, but because of much leakage the catheter was removed. I think the picture was more like that of acute nephritis with a constantly increasing blood chemistry rather than like that of any prostatic obstruction.

Clinical Diagnoses (from hospital record)

First admission

Cirrhosis of the liver, presumably alcoholic.
Secondary anemia.

Second admission

Portal cirrhosis.
Prostatic hypertrophy.
Hematuria.
Secondary anemia.

Third admission

Portal cirrhosis of the liver.
Acute yellow atrophy of the liver.
Acute nephritis.
Bronchopneumonia.
Benign prostatic hypertrophy.

Anatomic Diagnoses

Cirrhosis of the liver, toxic type.
Acute glomerular nephritis.
Hypertrophy of the heart.

Pathologic Discussion

Dr. Tracy B. Mallory: This is a case in which there was from beginning to end a great deal of argument as to the size of the liver. Our autopsy findings do not agree very well with any of the views expressed. If the clinical record is to be believed, within a period of eight days the liver shrank from four fingerbreadths below the costal margin to a liver that was not percussable below the costal margin, which seems like much too extraordinary a drop to be quite possible. At autopsy we found a liver weighing 1400 grams, very densely cirrhotic and very finely granular. The fibrosis looked as if it was very old. I do not believe that that liver could have varied significantly in size during the last year or more. It is possible that it may have been hypertrophied once, but certainly not recently. I certainly do not think the hypertrophy ever could have disappeared as rapidly as it apparently did according to the physical signs.

The other acute process that we found was an acute nephritis, glomerular in type, with innumerable pin-point hemorrhages all through the cortex of the kidney.

We were able to find very little in the way of prostatic disease, only slight hypertrophy of the median lobe. So we felt that the hematuria was best explained by the nephritis.

The question comes up of course whether in treating this man with mercurial diuretics one may have aggravated the nephritis.

Dr. Ludwig: Do you think the liver could have shrunk from 4 fingerbreadths below to the costal margin just through cirrhosis?

Dr. Mallory: I do not know enough about the time intervals involved there. It hardly seems to me reasonable. I could not swear it could not happen, but I certainly do not think that within a week or ten days it could have done so much shrinking. Also on the same day one could see marked differences between two examiners' estimates as to the size of the liver.

This is a section from the liver, showing very marked destruction of the architecture. We have a great many small quite uniform nodules

of regenerated liver tissue which have no central vein, quite irregular in composition. Between those nodules are bands of very dense fibrous tissue with some hyperplasia of the bile ducts and slight lymphocytic infiltration. The appearance is consistent with an inactive stage of alcoholic cirrhosis or a toxic type of cirrhosis. On the whole there is practically no fat vacuolization, which is rather against an alcoholic origin. The entire process looks like an old and slowly progressive liver disease rather than one which could be explained by any recent acute yellow atrophy.

This section is from the kidney. You can see the swollen glomerular tufts. You can see definite increase in the number of cells in the tufts, some of which are polynuclears. Occasional capsular spaces are filled with red cells. A large number of tubules contain red cells.

We have had a rather unusual run of cases with acute glomerular nephritis in people fifty years of age and over. Within the past six months we have had at least four cases of acute nephritis in people over fifty, one in the late seventies, nearly eighty.

DR. LUDWIG: Do you suppose this man could have had nephritis at the entry before the last one?

DR. MALLORY: No; that does not seem very reasonable.

DR. LUDWIG: We thought he was bleeding quite profusely by urethra. We thought it was possibly intravesicular bleeding due to the prostate.

DR. MALLORY: It is quite possible that there might have been some intravesicular bleeding, but there was certainly no marked prostatic hypertrophy. I do not believe that could have disappeared.

DR. O'NEIL: He might have had a certain amount of bleeding from the prostate, but it was not controlled by catheter drainage.

A PHYSICIAN: Was the heart increased in size?

DR. MALLORY: Yes; it weighed 450 grams.

CASE 18262

GASTRO-INTESTINAL TRACT BLEEDING

SURGICAL DEPARTMENT

PRESENTATION OF CASE

DR. LOGAN H. ROOTS*: This is the case of a sixty-five year old white Canadian widow. She was in the hospital a total of eight days. Her chief complaint was black stools. She said she had also had weakness and some fainting spells for two weeks, although she had had black stools only three days.

In view of the autopsy findings it is interesting that she had had a gall bladder operation. The gall bladder was presumably taken out twenty years before she was seen here. There is a question whether we should include in the present illness symptoms which occurred four years before entry, when she had gradual onset of anemia which her doctor thought was pernicious anemia. He treated her for it with liver diet and rest. She said her hemoglobin came up from 50 to 80. Otherwise she thought she was pretty well until two months before entry, when she began to have pain in the right side similar in some respects to a chronic pain that she had had most of her life along with a bad taste in her mouth. At the same time she began to have metallic tasting salivation. She did not pass any gas and she did not belch. There was no vomiting at all. At no time did she vomit any blood. The pain two months before admission did not persist very long, although the salivation did. She was fairly well until a week before entry, when she began to feel very weak and to go to sleep easily. Three days before entry she had black, evidently tarry stools, and her family noticed that she was very pale. One interesting item in her history is that her appetite remained good until the end. She never vomited blood.

In the hospital she was very weak in bed; she could not get up even for a chest film. She was pale and had a hard irregular mass in the epigastrium. Otherwise physical examination was essentially negative.

A gastro-intestinal series was done with the patient prone and less than the usual amount of barium for the meal. There was a filling defect in the lower half of the stomach. The barium enema was negative.

She had a red blood cell count of 2,000,000, on another occasion 1,600,000, hemoglobin 40 to 45 per cent, polynuclears 81 per cent. She had a normal white cell count. At two examinations done during the time before operation the urine showed a very slight trace to the slightest possible trace of albumin, white cells once, no casts, specific gravity 1.019 to 1.014. Her stool showed a four-plus guaiac.

She was here for six days before operation and was transfused twice. An exploratory laparotomy and resection of the stomach was done, Billroth II type, under avertin anesthesia supplemented by gas-oxygen. Her immediate recovery as far as blood pressure and pulse were concerned was good, but she did not come out of the anesthetic and was really in semicoma for two days. On the first postoperative day she had tracheal râles and was put in an oxygen tent. On the second day she began to fail. The blood pressure and pulse became very poor. Tracheal râles became more pronounced. The urine showed acetone and diacetic acid, a large trace of albumin and casts. There was no marked cyanosis even towards the end. On the third day she died.

*Junior interne on the West Medical service.

CLINICAL DIAGNOSES (FROM HOSPITAL RECORD)

Sarcoma of the stomach.
Chronic nephritis.
Bronchopneumonia.

ANATOMIC DIAGNOSES

Sarcoma of the stomach, probably leiomyosarcoma.
Operative wound: gastric resection, Billroth II.
Edema and congestion of the lungs.
Choledocholithiasis, ampulla of Vater.
Cervical polyp.
Arteriosclerosis.
Chronic vascular nephritis.
Acute esophagitis.
Acute periesophagitis.
Healed gastric ulcers.
Chronic adhesive pleuritis.
Hydrothorax, slight, right.
Secondary anemia.

PATHOLOGIC DISCUSSION

DR. TRACY B. MALLORY: The interesting finding in this case was the stomach tumor.

DR. AUBREY O. HAMPTON: I think I can demonstrate the filling defect in the stomach corresponding to the tumor. The defect has all the appearance of an extrinsic lesion except for this small fleck, probably an ulcer crater. I think it should be mentioned that it did not feel like carcinoma of the stomach. It felt soft and boggy instead of hard.

DR. MALLORY: The tumor here was a rather sharply circumscribed oval tumor not infiltrating to any extent the stomach wall. It was suggestively sarcomatous or at least edematous in the gross appearance. On the basis of the rush sections we thought it probably was a spindle cell sarcoma of the stomach, though it was not possible to make a positive diagnosis. As a matter of fact we have not got much further since that time.

The sections show that the greater part of the tumor consists of masses of rather small, not rapidly growing cells which have a marked tendency to be arranged about blood vessels. It is very difficult to be certain whether the tumor consists of blood vessels or whether it simply is showing a marked perithelial arrangement in which the cells in the immediate neighborhood of the vessels live and grow while those a very slight distance away are dying off. In a few areas we can find definite spindle cells and some produce very delicate fibrils. I think at least five pathologists have looked at the sections and we have had at least four diagnoses. The three best probabilities are myoma, fibroma and angioma, since these are practically the only three types of non-epithelial tumors one can get in the stomach except for lymphoma. That at any rate can be ruled out. Simply on numerical chances myoma is the likeliest. Those are by no means rare. Dr. Percy Davidson and I have been able to collect over forty cases from Boston hospitals without difficulty. Minute myomas have been found to be extremely common in the Mayo Clinic. Running through two hundred consecutive autopsies there they were able to find myomas one to nine millimeters in diameter in 16 per cent of all stomachs.* Usually such minute myomas are of no importance, though I have seen cases where their location just at the pylorus was associated with symptoms of obstruction. We have recently had a case associated with cancer where a small myoma was situated three or four centimeters from the cancer. The surgeon felt that it was probably an extension or a metastasis from the cancer, and for that reason enlarged his resection, when as a matter of fact it was quite unnecessary.

The story of this case is quite typical in that many of these cases are symptomless except for the story of passing blood by stool or vomiting blood.

DR. CHESTER M. JONES: Didn't you say that there was another patient who gave a history of tarry stools, then came back with further symptoms and finally had a negative exploration?

DR. MALLORY: That comes pretty close to it.

DR. LELAND S. MCKITTRICK: I believe that in all cases of hematemesis or melena we must explain the gastro-intestinal lesion. If the patient's condition is not critical due to the bleeding, every effort ought to be made to ascertain its source. If after careful clinical and laboratory investigation this cannot be done, exploration ought then to be advised, this to be done accepting the possibility that even at operation no adequate explanation may be found. On the other hand, in 50 to 75 per cent of the cases operation will show some definite lesion such as a bleeding ulcer, a carcinoma either of the stomach or the intestine, or one of the more unusual lesions of the small intestine such as leiomyosarcoma. In the group with acute hemorrhage it would probably be impossible to carry on a very extensive investigation unless the bleeding stopped. It has been the teaching of Dr. D. F. Jones that in these cases if bleeding continues after two or three transfusions, operation may then be definitely indicated and done in an effort to prevent the patient's dying from hemorrhage, it being better to operate early when the effects of transfusions seem better than they do after a number have been given in rapid succession.

DR. MALLORY: A very considerable percentage of these cases die of hemorrhage if untreated. Even the benign pedunculated and extragastric tumors may cause gastric hemorrhages. In those cases x-ray has been pretty uniformly negative. Where the projection is into the lumen of the stomach the percentage of positive x-ray findings has been increasing greatly of recent years. I think we can say that the majority of intragastric tumors are now being picked up by x-ray examination. Only five years ago that was by no means true.

*J. H. Rieniets, The Frequency and Pathologic Aspects of Gastric Leiomyoma. Proceedings of the Staff Meetings of the Mayo Clinic, Dec. 17, 1930, p. 364.

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PROSTATIC RESECTION

SINCE 1834, when Guthrie devised an instrument for cutting the median prostatic bar without open operation, the possibility of relieving certain types of prostatic obstruction by an intraurethral operation has been a matter of recurring interest to urologists. In the minds of most of us, the names of Mercier, Civiale, Bottini, Freudenburg, Chetwood and Goldschmidt are most closely associated with this problem.

Forty years ago, Doctor William N. Wishard of Indianapolis divided the median prostatic bar through a perineal incision with an electrically heated incisor. In 1908 Hugh Young produced his prostatic punch for the removal of certain types of obstruction at the bladder neck; in 1920 Caulk of St. Louis modified Young's punch by substituting an electrically heated circular knife in place of cold steel. This instrument was undoubtedly an improvement in that its use was attended by much less hemorrhage.

In 1913 Bugbee and also Stevens reported the destruction of middle lobes and median bars by electrocoagulation through the cystoscope. A decade later, the development of the diathermy cutting current and its introduction into surgery stimulated Maximilian Stern of New York to invent an instrument which by means of this current could be used intraurethrally to remove tissue from the bladder neck. An oil medium was required, and the instrument was never generally adopted. Collings, also of New York, presented his "electrotome", by means of which median bars could be whittled away with a high frequency current.

None of these instruments quite lived up to its reputation, yet all genito-urinary surgeons believed that there was a type of prostatic obstruction, found in small fibrous prostates and in some malignant prostates, which could theoretically be relieved by some method other than prostatectomy.

About three years ago T. M. Davis, then of Greenville, South Carolina, who was by way of being an expert in matters electrical, built himself a machine which supplied a high frequency current that would cut under water. He applied this current to a wire loop which moved within the lumen of an instrument something like a Young's punch, and by pressing different switches he could change the current from a cutting to a coagulating current. With this instrument he began to do what he termed "prostatic resection". The advantages of the method were numerous; the operation was done under vision, hemorrhage could be controlled by coagulation of bleeding points, the patient's postoperative stay in the hospital was reduced to from five to ten days, and the mortality was much less than that following the work of the average prostatectomist.

Numerous surgeons developed variations of Davis' instrument. Some of these antedated Davis' work, others followed it. Bumpus of the Mayo Clinic, Day of Los Angeles and Foley of St. Paul, Minnesota were among these. Davis' chief rival, however, was McCarthy of New York. McCarthy's instrument was an adaptation of the McCarthy panendoscope; through a non-conducting panendoscopic sheath a wire loop set at right angles to the long axis of the sheath is used to pare out the obstructing tissue. McCarthy terms this "revision of the bladder neck".

These methods—Davis' and McCarthy's—are the two most in favor, both being promoted by the manufacturers of the respective outfits. A wave of enthusiasm for prostatic resection is sweeping the country, spurred on by the demand by patients that they be relieved of their obstructions "without an operation".

Is this demand justified? Have we here a substitute for prostatectomy? Enthusiasts say that we have, that this method is applicable in at least 80% of all prostatic obstructions. The conservatives, whose position was ably stated by Hugh Young, hold that the method should be

employed only in a fairly limited class of cases. The operation requires anesthesia, usually sacral or spinal, and takes fully as much time as the average prostatectomy; anesthesia in a poor surgical risk is perhaps the greatest single factor in the mortality of prostatectomy. While median bars can undoubtedly be satisfactorily removed by this method, the large lateral lobes so frequently encountered are another matter. It may be true, as is alleged by the resectionists, that the formation of a channel through the median bar is all that is required to enable the patient to empty his bladder, but we cannot believe that the relief so afforded is anywhere near as complete as that given by actual enucleation of the lateral lobes. Undoubtedly brilliant results will at times be obtained by resection, even when large lateral lobes are present, but we believe that in such cases there will be many failures.

Secondary hemorrhages occur not infrequently, and every urological surgeon knows of cases in which the simple passage of a cystoscope induced a train of events fraught with the gravest consequences to the patient. In certain instances it is almost impossible to pass any instrument through the bladder neck.

The great danger inherent in a new method of this kind is that it will be employed by those who are not qualified to meet the situation in the conventional way. It is a method which should be used only by those whose experience enables them to select the cases suitable for its use, and to meet the surgical complications which may arise. In early hypertrophy, in median bars and in some malignant prostates, resection offers a new way of relieving urinary obstruction, but it should be attempted only by those trained in urethral instrumentation and experienced in the surgery of the prostate.

THIS WEEK'S ISSUE

CONTAINS articles by the following named authors:

JORESS, MARK H. M.D. Tufts College Medical School 1920. Resident Physician, State Sanatorium, Rutland, Mass. 1922-1927. Visiting Physician, Tuberculosis Clinics, Boston Health Department 1927-1932. Teaching Assistant, Pulmonary Diseases and Climatology, Tufts Medical School. Chief of Pulmonary Clinic, Beth Israel Hospital. His subject is "Surgical Treatment of Pulmonary Tuberculosis." Page 1331. Address: 483 Beacon Street, Boston.

MARSH, L. CODY. M.D. Albany Medical College 1929. Assistant Physician, Kings Park State Hospital, Kings Park, New York, and Worcester State Hospital. His subject is "Practical Aspects of Psychiatry for the General Practitioner." Page 1337. Address: Worcester State Hospital, Worcester, Mass.

GALDSTON, IAGO. B.S., M.D. Fordham University School of Medicine 1921. Executive Secretary, Medical Information Bureau, New York Academy of Medicine. Lecturer, New York University, New York City. Consultant in Health Education, National Tuberculosis Association. His subject is "Medical Publicity by Organizations and Individual Physicians." Page 1359. Address: 2 East 103rd Street, New York City.

FISHBEIN, MORRIS. M.D. Rush Medical College 1912. Editor, *Journal of the American Medical Association* and of *Hygeia*, the Health Magazine. His subject is "Medical Publicity and Advertising." Page 1361. Address: 535 N. Dearborn Street, Chicago, Illinois.

MISCELLANY

A RADIO MESSAGE PREPARED AND SPONSORED BY THE COMMITTEE ON PUBLIC EDUCATION OF THE MASSACHUSETTS MEDICAL SOCIETY FOR THE DEPARTMENT OF PUBLIC HEALTH

ROSE COLD AND HAY FEVER*

BY FRANCIS M. RACKEMANN, M.D.

There are a number of facts about hay fever which the Committee on Public Education of the Massachusetts Medical Society believes should be known by the public at large.

First, hay fever is a real disease. The victims of it really suffer and may be quite incapacitated during the season. Their bloodshot, swollen eyes, their itching, running noses and their paroxysms of sneezing are plain evidence of their misery. With these local symptoms go malaise, lassitude, and debility.

Secondly, the condition is common. About one per cent of the people in the United States have hay fever in one form or another. Persons of all races have it. The Negroes, the Chinese, and the Europeans are quite as susceptible as we. The American Indian, however, seems to be less susceptible, though one or two cases have been reported from the Reservations. In the tropical countries of South America, hay fever is either absent or very rare. It is a disease of the temperate zones including perhaps the uplands in the warmer climates.

Thirdly, the cause of hay fever is very definite and in it two factors are involved. One is the victim himself; the other is the particular plant and the pollen which it produces.

Why is it that only one person in a hundred is afflicted with hay fever? If this question could be answered accurately, the treatment of hay fever would be immensely simplified and we would probably be in a position to cure asthma and perhaps to cure arthritis and rheumatism as well, for there is

*Broadcast: March 29, 1932. Station: WBZ—Hotel Bradford. Time: 5:00 to 5:10 P.M.

reason to believe that these more serious disturbances depend upon a background quite similar to that of hay fever. At all events, the common relationship accounts for the doctors' interest in hay fever which is the simplest example of this group of diseases.

Nowadays, everyone knows that hay fever is due to the pollen of plants. For some reason the victim has a capacity to become sensitive to the pollen and by virtue of this sensitiveness he has the capacity to react in a violent manner when exposed to even a minute quantity of it. He is said to be "allergic". Other allergic persons are sensitive to horses, cats, feather pillows, silk floss mattresses, orris powder, and wheat flour, not to mention foods, and they react violently to the offending substance. Sometimes they sneeze and have a winter form of hay fever. Sometimes they wheeze and have asthma. Sometimes they itch and have eczema. In each case, the fundamental mechanism is probably the same. Unfortunately, however, the nature of this mechanism is still unknown.

In more than half the cases, the allergy is inherited, and from the father and mother with equal frequency. It may show itself at any age, most commonly between 10 and 25, but numbers of people develop hay fever after 40 and a few after 50. Incidentally, the victims are of all sizes and shapes. The fat and thin, short and tall, blonde and brunette, men and women, are all to be seen in the hay fever clinic.

Pollen is a very fine yellow powder which is produced by the male elements of plants and is transferred to the female elements either by insects or by the wind. All flowers are insect pollinated; their bright colors are designed to attract bees and flies; their pollen is relatively large, heavy, and sticky. It is not blown about by the wind and, therefore, is not ordinarily a cause of hay fever.

Trees, grasses, and weeds have flowers to be sure, but they are very inconspicuous. Nevertheless, they produce immense quantities of a light, dry, almost invisible pollen which comes off in veritable clouds and is carried for long distances floating in the wind. This air-borne pollen is the cause of hay fever. Did you ever see the catkins on the elm trees, the birches, oaks, and maples? These are the tree flowers. For each tree, the flowering season comes in April or May and is very short, lasting only about a week. Tree hay fever is usually unimportant unless the patient is sensitive to several trees which pollinate at different times.

The grass season is more important. Lawn grass and hay grow everywhere both in town and country and the several kinds like timothy, red top, June grass and orchard grass blossom about the first of June and give off pollen until the middle of July. Large numbers of persons have hay fever at just this season in New England. In the West and South, the grass season is longer and in certain states like Texas and California, it occurs twice—in the fall as well as in the spring.

"Rose fever" is a common expression. The fragrant blooms are obvious in the June garden but for each rose in view, there are probably a million ripe heads of grass not far away.

In August and September, weeds become important. In New England, the worst offender is ragweed, a greenish plant varying from one to four feet in height with fernlike leaves and covered with upright spikes which bear a multitude of minute greenish flowers. Ragweed blossoms everywhere along the highways, in dumps, and on all vacant land. It produces pollen in large quantities, from the fifteenth of August until the frost kills it. Other weeds, like plantain, pigweed, lambs' quarters, and sage are relatively unimportant. Studies from aeroplanes have proved the presence of ragweed pollen in the air as high as 6000 feet. The amount of it is enormous. It has been calculated that during the ragweed season, the air over Indianapolis carried a total of three tons of pollen, and in the country, the quantity is much larger. Obviously, it helps to pull the ragweed in the back yard but obviously, also, to clean one small area will not help very much. Rain, of course, washes the pollen out of the air, but it makes the weeds grow and when the sun comes out again, more pollen than ever is produced. Cold, however, greatly reduces pollen production.

During the ragweed season of 1931, the pollen was first demonstrated on August 9 and calculated as one grain per cubic yard of air. On the twenty-first, the figure was fourteen grains and on the twenty-ninth, twenty-six grains. On Sunday, August 30, the count shot up to eighty-six grains and most patients were miserable that Sunday. The next week was cool and the pollen concentration dropped to twenty-four, but the Labor Day week-end was hot again and the pollen figure was again over eighty—more misery for hundreds of people.

What about treatment? First of all, it is known that one-third of all patients with hay fever wheeze and complain of shortness of breath when their attack is severe. It is these cases which particularly need treatment so as to forestall the development of pollen asthma. Temporary deafness, dependent upon chronic congestion of the nose, is another reason to seek relief if possible.

The treatment of hay fever is satisfactory in about 75% of the cases. It begins with a skin test to make sure that the patient is really sensitive to the particular pollen suggested by the dates on which his symptoms occur. At the same time, the skin tests indicate the degree of sensitiveness and whether large doses or small doses will be required. Treatment consists in a series of doses of the pollen extract given hypodermically at intervals of from three to seven days. Ordinarily about a dozen treatments are necessary. In each instance they must be carefully graded to suit the individual patient, for otherwise they will do no good and may

do harm. As most of the doses must be given before the season starts, it is clear that the treatment should begin about eight weeks before the time of hay fever. The grass cases should begin in March or April; the ragweed cases in June. Individuals sensitive to both grasses and weeds have double hay fever and usually require double treatment. Pollen treatment must be repeated each year. It is found, however, that as time goes on the number of doses can be reduced and the procedure greatly simplified.

In all large cities there are physicians who have the special training and the materials for treating hay fever and preventing its complications. Moreover, the out-patient departments of most of the larger hospitals have special clinics for asthma and hay fever. The treatment is, therefore, available to all. Unfortunately, the results are not perfect, although they are much better than the attempts to control the symptoms with various sprays, washes, and ointments applied to the eyes and nose directly. When further study enables us to modify the underlying reaction capacity—the allergy—then the problem will be solved.

THE ELIMINATION OF CERTAIN HEALTH ACTIVITIES IN MALDEN, MASSACHUSETTS

An interesting example of the modern health education of a community has just been given by the very general protest of the citizens of Malden against certain cuts in the budget of the Health Department actuated by the desire to effect economies in the costs of municipal administration. These reductions, if they remain effective, will eliminate the baby clinics, preschool clinics, dental clinics, and do away with the school nurse system in the private schools, for the reason that public funds will no longer be available for their support.

Health administration in Malden is rather unusual, involving the close and practical coöperation of the Health Department, the voluntary agencies and the School Department, and the quick taking over by the Health Department of activities inaugurated by the voluntary societies. The health education in the public schools is, moreover, of unusual type. The Superintendent of Schools, Farnsworth G. Marshall, on the basis of plannings by Professor C. E. Turner of Massachusetts Institute of Technology, has made the care of health a regular subject in the school program. The system has attracted wide attention, and has been adopted for the foundation of similar health education programs in prominent cities of the West. The children, being to a large extent the custodians and caretakers of their own health, very quickly realize the importance of public health administration, and are indeed missionaries of health in their own homes. Of course the School Department has also its regular staff of school nurses for inspection and follow-up work in the home. The combination of these various factors has resulted in a public appreciation of the value of health work which has caused vigorous protests in the present emergency.

In addition Malden has been fortunate in the early establishment of voluntary agencies, which have always been prominent in efforts to try out promising lines of health experiments. The Malden Tuberculosis Society established a baby clinic, and its success was so evident that it was very soon taken over by the Board of Health. Next in order, the Red Cross established a preschool clinic, and this has likewise been made a regular part of the Board of Health program. In both these matters the voluntary agency transferred the work to the Health Department, and established for itself new lines of effective effort. The tuberculosis society founded a health camp, and, this becoming a separate corporation, the parent society was relieved of its care, but still is helpful in that it contributes a substantial gift of money, and furnishes x-ray examinations and other aid which no other agency is prepared to finance.

Finding that the parochial and other private schools of Malden, with a pupil population of about 3,000, had no system of school nursing, the enterprising Health Department took a long step forward in supplying this service, and established in the schools an excellent system of inspection and follow-up. Incidentally, among other clinics there was established a dental clinic for children.

How active the Board of Health has been in the specialties enumerated may be judged from the following figures:

Baby clinic	2,200 cases
Preschool clinic	452
Infantile paralysis	17
Dental clinic	1,421
Total	4,090 cases

Baby clinic, preschool clinic, dental clinic and school nursing service for private schools are not financed in the "economical" budget before the city government.

No less than ten of the prominent societies of the city have voted in protest at their meetings against the omission of these health items from the budget. Petitions signed by individuals have been freely circulated and many letters have been printed by the local newspaper. One result has been that the situation has been thoroughly discussed by the Board of Aldermen and the City Council. The latter has refused thus far to approve the budget and has voted a matter of amendment which will take it again before the Aldermen who approved it some time ago. The legal situation is that the Mayor presents the budget to the Aldermen and Council. They have authority to decrease the appropriation for any of the items, but cannot increase it. As a "gesture" either body may refuse to pass it, but then it will automatically become effective after sixty days.

The situation in Malden is very interesting to the health officer since it shows how the regular pro-

gram of a health department may be set aside by city officials. It remains to be seen whether the Mayor will hold to his original plan despite the widely-voiced disapproval of a goodly number of the citizens.

SMALLPOX DECLINES

Reports from 43 states, the District of Columbia and eight Canadian Provinces indicate a decided decrease in the prevalence of smallpox in these areas during 1931, according to a bulletin recently issued by the Metropolitan Life Insurance Company. Despite this trend the case-fatality rate showed no appreciable reduction.

The total number of cases declined from 44,977 in 1930 to 26,869 in 1931. In the United States alone the drop was from 43,964 cases to 26,004 and in Canada from 1,283 to 865.

Lest we become too complacent, the report states that it is well to realize that of the 26,004 cases of smallpox in forty-three states at least 86 per cent or 22,413 cases occurred in but nineteen states lying chiefly in the north central and western sections of the country. Two states, Kansas and South Dakota, reported more than one case per thousand of population and three others, Indiana, Iowa and Vermont, just barely missed that ratio. Indiana alone recorded more than three thousand cases.

The states just mentioned are, by and large, those in which there is no general acceptance of the value of vaccination and revaccination as preventive measures against smallpox. Fortunately the states on the Atlantic seaboard have been more exempt from the disease than the middle and western states, because of better application of preventive measures.

It is evident from this report that this large insurance company is thoroughly convinced that vaccination is a very important life-saving procedure.

RECOGNITION OF THE MEDICAL PROFESSION BY RADIO

For the first time in the history of commercially sponsored radio broadcasting the medical profession is to receive the recognition that is its due.

In his newest series of programs, which he has called "The Country Doctor," Phillips H. Lord pays tribute to medical men of all classes and particularly to those who minister to the ills of the millions in the rural communities throughout the country.

The new program was heard for the first time on Monday, June 20, at 10 P.M., New York time, over WJZ and the nation-wide N. B. C. "blue network". The programs will be 15 minutes in length and will be broadcast each Monday, Tuesday and Wednesday night.

Mr. Lord has named his character Dr. Matthews, a kindly, gentle physician who might be found practicing in any of the thousands of small towns which dot the nation from coast to coast. He is skilled in the practice of his profession and shrewd in his judgment of his neighbors. He is tolerant when he may be and stern when he must be and in his daily routine plays the rôles of brother, counsellor and friend.

As Mr. Lord pictures him his suit may need pressing, his office may be crying for the touch of an orderly hand, and his bank balance might be better for the assistance of someone to collect his fees for him, but he is always ready, always efficient and always calm. He is solid rock, part scientist, part philosopher and part priest, and around him, in fair weather and in storm, sweep the waters of the community's life.

TOO MANY FRENCH DOCTORS

The belief that the number of physicians increases faster than the demand for them is apparent in the reports from Paris which have appeared in the literature in that country. It is found that the number of graduates of recent years corresponds to a total of 33,600 physicians, although the present total of 28,000 physicians constitutes for France one physician for a little more than 1400 inhabitants.

It is generally recognized that the inability of certain medical schools of the United States to accept more applicants has resulted in the migration of a considerable number of young men for study in England and continental Europe, all of which tends to show that there is an ambition on the part of young men to enter the medical field in excess of what appears to be a reasonable demand for physicians.

THE 1932 GRADUATE FORTNIGHT OF THE NEW YORK ACADEMY OF MEDICINE

Tumors, benign and malignant, will be the theme of the 1932 Graduate Fortnight of the New York Academy of Medicine. The medical profession of the country is invited to participate in the intensive two-week study of this important medical and surgical subject.

A full program of clinical demonstrations, lectures and conferences has been arranged to cover all phases of tumors, their diagnoses and treatment.

Concurrent with the Fortnight, and for an added week thereafter, there will be housed in the Academy building an exhibition of anatomical specimens numbering approximately 3000 units. A number of the sections in the exhibition will be subjected to lecture demonstrations at regular intervals.

Ten evening meetings have been arranged during which tumor growths in various parts of the human anatomy will be discussed. Among the speakers are included Doctors W. Gordon M. Byers, Edwin Beer, Charles A. Elsberg, James Ewing, Donald C. Balfour, Daniel F. Jones, Dean Lewis, Francis Carter Wood, and others.

Thirty afternoon clinical meetings and demonstrations have been arranged in eighteen of New York City's leading hospitals, including Bellevue,

Lenox Hill, Presbyterian, St. Luke's, Fifth Avenue, Post-Graduate, Neurological Institute and others.

The Fortnight will be held from October 17 to 28 inclusive.

The profession of the country is invited to attend and to participate in the Graduate Fortnight. There is no charge for attendance at any of the clinics or meetings, but registration is required for participation in the hospital demonstration clinics.

A complete program and registration blank for the clinics and demonstrations may be secured by addressing the New York Academy of Medicine, 2 East 103rd Street, New York City.

MORTALITY RATES

Telegraphic returns from 85 cities with a total population of thirty-seven million for the week ending June 11, indicate a mortality rate of 10.8 as against a rate of 10.7 for the corresponding week of last year. The highest rate (18.1) appears for Memphis, Tenn., and the lowest (4.9) for Hartford, Conn. The highest infant mortality rate (17.4) appears for Duluth, Minn., and the lowest for Evansville, Ind., New Haven, Conn., Oakland, Calif., Springfield, Mass., and Waterbury, Conn., which reported no infant mortality.

The annual rate for 85 cities is 12.2 for the twenty-three weeks of 1932, as against a rate of 13.1 for the corresponding period of the previous year.

ABSTRACTS FROM THE HIGH COST OF MEDICAL PERIODICALS

By Fielding H. Garrison, M.D., Librarian, Welch Medical Library, Baltimore, Md.*

The following interesting abstracts appear as comments on the war and postwar conditions:

"And what was happening to medical literature all this while? Maintained at the ordinary level for a few weeks after the declaration of war, it had, by the beginning of 1915, deteriorated perceptibly, both as to quality and quantity. In Russia after the Revolution, it became virtually non-existent, and while Germany, Italy, Switzerland and the Scandinavian countries kept up their quota fairly well, several important French periodicals were discontinued in mid-course, England cut down on the publication of books at a certain point and Austria, in particular, Vienna, experienced the extremes of war-impoverishment. For a long time after the Armistice, the quality of the output of medical literature was poor or trivial. Even the German medical journals at the period were full of trash, and until the old *valuta* of the *Reichsmark* was established, there seemed to be little incentive to improvement. With the rehabilitation of the *Reichsmark*, however, the fictive high prices of medical periodicals, which had obtained perforce under lower *valuta*, were maintained. In other words, physicians and medical libraries found themselves paying unheard of prices for these items. Something similar has been going on latterly with regard to the prices of a few American medical periodicals since the financial crash of 1929. The exhaustive tabulation by Robert and Schaltenbrand, in this number, goes to show, in fact, that the foreign rates of some current European medical periodicals are no higher than those of some American medical periodicals, of the same quality and format, since the slump of 1929. The great stumbling block, for medical librarians and research workers of moderate income, has been the cost of certain German medical periodicals of strictly scientific type, printed in the very best manner, on superior paper, sometimes with expensive illustrations, but at rates which are now prohibitive. Single numbers of these periodicals may cost anywhere from $5.00 to $10.00. A volume usually comprises 4-6 of such numbers, and in the case of such periodicals as *Virchow's Archiv* or the *Biochemische Zeitschrift*, there may be as many as 4-14 volumes per annum, bringing the annual subscription rate up to around $100. This would have been unthinkable before the war. On the other hand, these very periodicals, almost without exception, pay the scientific physicians who contribute articles, at a flat rate of 40 marks per 16 pages and 100 reprints for articles of not more than 16 pages (50 reprints for longer articles). They seldom, however, state a flat annual subscription rate, which is disingenuous, although the high price of separate numbers is sometimes featured at the bottom of the cover. English and American medical periodicals, of the same scientific type, almost invariably state the annual subscription rate on the front or back or withinside the cover. Very few of the English and almost none of the French or American medical periodicals pay their contributors or furnish reprints *gratis*. As a rule, too, payment to contributors is sometimes confined to citizens of the country, or to put it differently, contributors, since the war, are usually native sons, and the outland contributor, who expects an honorarium, will find himself at pains to collect it. It is like the old proverb of Scotch fisher folk: We maun gie our ain fish-guts to our ain sea-mews.

"From the careful tabulations made by Messrs. Robert and Schaltenbrand in this issue, it is plain that the foreign subscription rates of American medical periodicals of whatever type are usually lower and more reasonable than those of European periodicals of the same type; that the cost of the big German weeklies, of the type of the *Journal of the American Medical Association*, is lower than that of the *British Medical Journal* or the *Lancet;* that the cost of the French medical periodicals is, at present, lowest of all, by reason of the extremely low *valuta* of the franc, and that the cost of the German medical periodicals of scientific types is, in some cases, prohibitive. At the same time, the subscription rates of certain foreign and domestic periodicals approximate to about the same figure. The first group cov-

*Bulletin of the Medical Library Association. N. S. XX, No. 4, April, 1932, Cleveland, Ohio.

ers items at $5-$6 per annum. Of these *Brain* (26), *Human Biology* (54), *Isis* (56) and *Janus* (57) might be described as bargains. In respect of quantity and variety of material and illustrations, the *Journal of the American Medical Association*, at $3.50 per volume, is the most reasonable of all in price. With regard to quality of material, the *Bulletin of the New York Academy of Medicine* (12 numbers at $2.00 *per annum*) is the most exemplary and deserving medical periodical in the world. Items in Group II are to be had at about $7 *per annum*, items in Group III at about $8-$9 *per annum*, items in Group IV at about $10.00 *per annum*."

ONE COMFORT INCIDENT TO THE DEPRESSION

Secretary Wilbur of the Interior and Chairman of the White House Conference has indicated his belief that more attention is given to the health of children during periods of depression than in prosperity, for parents seem to have assumed the responsibility of caring for their children instead of transferring the supervision to others.

In prosperous times parents in comfortable circumstances resort to various methods of entertainment which take them from home and divert attention from the care of their children, so that Secretary Wilbur believes that we may find some benefit accruing from the unfortunate conditions incident to the depression.

THE CORRELATION OF CANCER RESEARCH

Throughout the world there are many persons studying cancer and striving to unravel its mysteries. To Mr. William H. Donner the concentration and direction of the work of this army seems of great importance and has led him to endow the International Cancer Research Association with two million dollars.

While it is true that many discoveries in medicine and allied sciences have come about through individual effort the likelihood of any great advances in scientific medicine by detached research workers is growing less. Virile and inquiring minds have always been able to make progress in pioneer fields but we have probably gone so far in probing the causes and behavior of disease that the opportunity of the individual to unlock the hitherto closed doors of complicated pathologic processes is not large. Mr. Donner is probably right in his conception of the necessity of a broad and intensive attack on the cancer problem, because the great advances in industrial fields have come about by coördinate concentration of effort under competent direction as shown by the progress made in the application of electrical energy and other agents in adding to the efficiency of public service organization.

It has been well said in an editorial in the *New York Times* that "the problem of Cancer is a problem of life, of the cell and therefore a biologic, physical and chemical problem". This means the coördination of the work of the physicist, biologist and chemist.

While individuals or groups may have made some progress, the subject is so broad that it becomes practically certain that all acquired facts should be submitted to a great organization which can correlate and direct research.

This endorsement seems to warrant the hope of more progress in this subject and places Mr. Donner in a prominent position among the contributors to human welfare.

THE DEFENSE OF OUR COUNTRY AGAINST DISEASE

The United States Public Health Service is charged by law with the defense of our country from invasion by contagious diseases from foreign countries especially cholera, yellow fever, smallpox, typhus fever, leprosy, plague and anthrax. In order to do this there is not only an effective quarantine service at all ports of entry in this country and its insular possessions, but this is supplemented by an epidemiologic intelligence service furnished by American consuls at foreign ports. This custom has been followed since 1881 when an international sanitary conference was held in Washington on call by the United States Government which invited the maritime powers of the world to meet for the purpose of considering an international system of notification of the actual sanitary conditions of ports and places under the jurisdiction of such powers. The effect of this coöperative effort has been to prevent the dissemination of disease in this country.

NOMINATIONS BY HIS EXCELLENCY GOVERNOR ELY

The following names have been presented to the Council by Governor Ely:

Thomas B. Alexander, M.D. of Scituate to continue as Associate Medical Examiner for the fifth Plymouth District.

Carl E. Richardson, M.D. of Franklin to continue as Associate Medical Examiner for the sixth Norfolk District.

Michael James Shaughnessey, M.D. of Framingham, Medical Examiner for the eighth Middlesex District in place of James Glass, M.D.

Frank A. Bragg, M.D. of Foxboro reappointed Medical Examiner for the sixth Norfolk District.

William H. Kelleher, M.D. of Woburn, Medical Examiner for the fourth Middlesex District in place of Vernon C. Stewart, M.D.

John P. Reardon, M.D. of Somerville, Medical Examiner for the second Middlesex District to fill the position formerly occupied by the late Charles P. McCaffrey, M.D.

All of the nominees are members of the Massachusetts Medical Society.

CORRESPONDENCE

AN ANNOUNCEMENT RESPECTING THE INFANTILE PARALYSIS COMMISSION

The Commonwealth of Massachusetts
Department of Public Health
State House, Boston

June 20, 1932.

Editor, *New England Journal of Medicine,*

This coming summer the Harvard Infantile Paralysis Commission finds itself unable to continue the consultation and serum service which has found such favor with the physicians in previous years.

In order that serum may be available for those cases in which it is indicated, the Department is making arrangements for its collection and limited distribution. So far as possible local resources will be utilized, supplemented by such consultation service through the Department as may be necessary in special instances. In the near future we hope to be able to announce the local arrangements whereby serum can be made available in the several large centers.

During the coming summer, effective July 1, and until further notice, all calls for infantile paralysis serum and consultation service will be handled through Kenmore 8100, where service will be available at all hours.

Yours truly,
GEORGE H. BIGELOW, M.D.,
Commissioner of Public Health.

OFFICIAL DECISIONS BY THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE

The Commonwealth of Massachusetts
Department of
Civil Service and Registration
Board of Registration in Medicine
State House, Boston

June 25, 1932.

The *New England Journal of Medicine,*

At a special meeting of the Board of Registration in Medicine, on June 23, 1932, the following votes were passed:

(1) To restore the license of Dr. John J. Cummings, of 185 Crescent Street, Brockton, Massachusetts, which had been cancelled on December 3, 1919, on account of drug addiction.

(2) To suspend the license of Dr. Carlos Mata, of 345 Hanover Street, Boston, Mass., for one month ending July 25, 1932, for deceit in the practice of his profession.

(3) To suspend the license of Dr. Frank Steele Garrett, of 242 Washington Avenue, Chelsea, Mass., who has been admitted to the Danvers State Hospital.

(4) To revoke the license of Dr. Dixi G. Hoyt, of 109 West Street, Leominster, Mass., because of his court conviction on the charge of performing an illegal operation.

STEPHEN RUSHMORE, M.D., *Secretary.*

ARTICLES ACCEPTED BY THE AMERICAN MEDICAL ASSOCIATION COUNCIL ON PHARMACY AND CHEMISTRY

535 North Dearborn Street, Chicago, Ill.,
June 25, 1932.

Editor,
The *New England Journal of Medicine,*

In addition to the articles enumerated in our letter of May 28 the following have been accepted:

Eli Lilly & Co.
Ampoule Sodium Amytal 0.25 Gm. (3¾ grains)
Ampoule Sodium Amytal 0.5 Gm. (7½ grains)
Ampoule Sodium Amytal 1.0 Gm. (15½ grains)
Liver Extract No. 343, 110 Gm. bottle

Winthrop Chemical Co., Inc.
Ampules Luminal-Sodium (Powder) 5 grains
Capsules Luminal-Sodium 5 grains
Luminal-Sodium Tablets, ¼ grain
Luminal-Sodium Tablets, ½ grain

Yours truly,
W. A. PUCKNER, *Secretary,*
Council on Pharmacy and Chemistry.

RECENT DEATHS

HINCHEY—RICHARD HINCHEY, M.D., died at his home in Waltham, June 20, 1932. He was born in Lexington and graduated from the Massachusetts School of Pharmacy in 1892 and the Medical School of Harvard University in 1898. He joined the Massachusetts Medical Society in 1905 and had practiced medicine in Waltham, Mass., for the past thirty years. He had served as the assistant medical examiner of his district, and school physician for Waltham. He was a captain in the medical corps during the World War.

Dr. Hinchey was a member of the staff of the Waltham Hospital and president of the Waltham Medical Club.

He is survived by his widow, Mrs. Winifred Hinchey, and three children.

HUBBARD—FRANK ALLEN HUBBARD, M.D., died at his home in Taunton, Mass., June 21, 1932.

He was born in Worcester, Mass., March 8, 1852, the son of Dr. Simeon P. and Harriet A. (Barrett) Hubbard. He graduated from Harvard University in 1873 and from the New York University Medical College in 1878. His medical education included courses in Vienna and soon after he took up residence in Taunton with his parents and entered upon the practice of medicine.

He joined the Massachusetts Medical Society in 1883 and secured recognition as an active member as shown by election as Vice-President in 1890, President in 1891 and 1892, Commissioner of Trials in 1899, 1900 and 1902. He became Supervising

Censor in 1895 continuing to 1899 and from 1907 to 1932. He was censor from 1900 to 1906.

He served on the Council in the years 1893 to 1899 and from 1907 to 1932 and also served on important committees from time to time.

His interest in local medical affairs is shown by membership on the surgical visiting staff of the Morton Hospital for thirty-five years, trustee of the Morton Hospital and President of the Taunton Doctors' Club.

Dr. Hubbard has been regarded as the Dean of the medical profession in Taunton and this recognition led to a testimonial banquet in his honor by his local associates and prominent practitioners in New England last April. On this occasion he gave an interesting address in which he discussed the changes in medicine coming under his observation during a practice of fifty years.

He had great interest in the civic affairs of his city responding often to calls for service.

Dr. Hubbard was twice married. His first wife was Miss Annie Field of Taunton who died many years ago leaving a son Merrill F. Hubbard. Several years later he married Miss Elizabeth Wheeler who survives him with three daughters, Mrs. Marshall Farnham, Mrs. Charles Linscott, Mrs. Milton Bonner and two sons, Dr. Edward R. Hubbard now an intern at the Boston City Hospital and Leonard F. Hubbard recently receiving a degree from the graduate school of Boston University.

Dr. Hubbard attended the last annual meeting of the Massachusetts Medical Society apparently in good health. He passed away in his bed at night without evidence of conscious suffering.

NOTICES

REMOVAL

Dr. Elliott C. Cutler's address on and after August 1, 1932, will be the Peter Bent Brigham Hospital, Boston.

RADIO HEALTH MESSAGES

JULY 5, 1932

Sponsored by the Public Education Committee of the Massachusetts Medical Society and the Massachusetts Department of Public Health.

Courtesy WBZ. Tuesday, 4:20 P.M.

July

5 How Are Your Arteries?

This concludes the present series of broadcasts. The new series will begin in September.

REPORT OF MEETING

REPORT OF THE NATIONAL TUBERCULOSIS ASSOCIATION ANNUAL MEETING HELD JUNE 6-9, 1932

Five hundred and fifty persons including physicians, nurses, and lay health workers were registered at the twenty-eighth Annual Meeting of the National Tuberculosis Association held at Colorado Springs, June 6-9.

Dr. Alfred Henry of Indianapolis was succeeded in the Presidency by Dr. John H. Peck of Iowa. Other officers elected were: Dr. L. J. Moorman of Oklahoma, and Dr. Harry L. Barnes of Rhode Island as Vice-Presidents; Charles J. Hatfield, M.D. of Philadelphia as Secretary; Henry B. Platt of New York as Treasurer; Executive Committee, Drs. Kennon Dunham of Cincinnati, Alexius M. Forster of Colorado, Alfred Henry of Indianapolis, Esmond R. Long of Chicago, Leroy S. Peters of New Mexico, James A. Price of Tennessee, and Willard B. Soper of Connecticut.

The Trudeau Medal for eminent achievement in the field of research in tuberculosis was awarded to Dr. Esmond R. Long of the University of Chicago. This medal was presented at the opening session on Monday, June 6, by Dr. Henry Sewall of Denver.

One of the features of the meeting was a dinner at the Broadmoor Hotel, Colorado Springs, in celebration of the Fiftieth Anniversary of the Discovery of the Tubercle Bacillus by Dr. Robert Koch. A memorial address was given on this occasion by Dr. Gerald Webb of Colorado Springs.

Sectional programs on clinical tuberculosis, the pathology of tuberculosis, and the sociological aspects of the problem were held throughout the three days of the meeting.

The American Sanatorium Association which meets at the time and usually at the place of the National Tuberculosis Association meeting had a one-day session at the Colorado School of Medicine at Denver, on Monday, June 6, and a second day session at the headquarters of the National Association meeting on Tuesday, June 7. Dr. Harry L. Barnes, Superintendent of the Rhode Island State Hospital at Wallum Lake, Rhode Island, is President of the Association.

Dr. Olin S. Pettingill, Superintendent of the Essex County Sanatorium, and Frank Kiernan, Executive Secretary of the Massachusetts Tuberculosis League, attended the Annual Meeting from this State.

Mr. Kiernan gave a paper on the program with Dr. Kendall Emerson, Managing Director of the National Association, on Health Education Demonstrations in Massachusetts High Schools.

Mr. Willis Chandler, Executive Secretary of the Rhode Island Tuberculosis Association, was elected Chairman of the Special Committee to promote after-care of patients discharged from sanatoria.

Mrs. Alice McGouldrick, of Augusta, attended the meeting representing the Maine Public Health Association, and Miss Mabel Baird, Field Director of the Connecticut Tuberculosis Commission, attended representing the organization in that State.

SOCIETY MEETINGS

CONGRESSES AND CONFERENCES

July 10 - August 12—The Second Intensive European Summer Course in Surgery, Gynecology and Obstetrics. See page 714, issue of March 31.

September 19-22—International Congress of Biliary Lithiasis. See notice on page 427, issue of February 25.

October 17-21—Clinical Congress of the American College of Surgeons. See page 1330, issue of June 23.

October 17-28—The 1932 Graduate Fortnight of the New York Academy of Medicine. See page 1375.

October 24-27—American Public Health Association. See notice on page 1321, issue of December 31.

October 24-28—Inter-state Postgraduate Medical Association of North America. See page 39, issue of January 7.

BOOK REVIEWS

The Surgical Clinics of North America. Volume 12, Number 1. February, 1932. Chicago Number. W. B. Saunders Company, Philadelphia.

This issue opens with a thorough discussion of abdominal actinomycosis by Bevan. Most cases are operated upon with the diagnosis of acute appendicitis. All fistulous tracts should be widely opened and packed with gauze soaked in 2% copper sulphate solution. Iodides are given by mouth, x-ray treatments used, and the general hygiene of the régime for tuberculosis is followed. With Abbott he gives a very thorough discussion of a case of penetrating gastric ulcer for which a radical resection was done.

Kellogg Speed presents four cases of common peripheral nerve injuries. A fracture of the olecranon resulted in an ulnar neuritis that was relieved by neurolysis and transplantation of the nerve. Osteomyelitis of the humerus resulted in like damage to the radial nerve which in turn was similarly relieved by neurolysis. In a case of gunshot wound of the humerus with wide destruction of the radial nerve, no attempt was made to suture the nerve, but tendon transplantation was to be done. A divided radial nerve was sutured after excising the scarred ends, the sutures being placed in the neurilemma without perforating the nerve itself. The general principles of nerve repair are outlined.

Moorehead gives an interesting clinic on plastic surgery of the jaw, nose, and cheek.

Benign hypertrophy of the prostate is very ably discussed by Kretschmer. He emphasizes the importance of careful preoperative care and especially a large fluid intake. Vasectomy at the time of insertion of an indwelling catheter is recommended to prevent epididymitis.

Hedblom and Van Hazel present four cases illustrating different types of surgical treatment of early pulmonary tuberculosis with arrest of disease in all including a case of tuberculous empyema treated by extrapleural thoracoplasty.

Shambaugh outlines the present-day treatment of mastoiditis and of maxillary sinusitis. He cautions against placing too much reliance upon x-ray examination of the mastoid. In general the cure of maxillary sinusitis requires a large opening into the nose.

A satisfactory method of reconstruction of the common bile duct is described by McWhorter and a case presented eight years after hepaticoduodenostomy. He advises riband end-to-end suture of the common duct with proximal diversion of the bile.

Christopher demonstrates some excellent results obtained by open operation in very difficult fractures, viz.: compound comminuted fracture of the distal end of the humerus, double fracture of the femur, and avulsion of the tibial spine by the anterior crucial ligament.

Montgomery reports a case of massive effusion in the pericardial cavity satisfactorily treated by rib resection and tube drainage.

There are several other clinics that add to the interest and value of this volume.

Modern General Anesthesia. A Practical Handbook by JAMES G. POE, M.D. Second Edition. 1932. F. A. Davis Company, Philadelphia. Price $2.50.

Anesthesia, an important and practical subject, is taught in few medical schools. Students at George Washington University, University of Wisconsin, Tufts, Baylor, and some others, have the advantage of courses in anesthesia given by competent anesthetists. An alibi sometimes heard is that anesthesia can't be taught. But that it can be, Poe demonstrates, and his book takes us through his course at Baylor, freely, easily, understandingly.

Most textbooks on the subject are long, tiresome and technical; qualities from which Poe's book is free. It is especially valuable for its presentation of the inhalation anesthetics, nitrous oxide, ethylene, and ether. A practical chart is presented, on which any given case can be sketched in graphic form. In even a small group like the Boston Society of Anesthetists no chart can be produced with the details of which all would agree; however the main features of Poe's chart are beyond controversy, and for teaching purposes some method of graphic presentation is extremely valuable.

By way of criticism, no book on Anesthesia can truly be called "Modern" without mention at least of Waters' Carbon Dioxide Absorption technique, whether one is "sold" on the idea or not. Your reviewer, however, believes that method to be an epochal step in modern anesthesia.

The chapter on spinal is not convincing, and is illustrated by drawings from Labat, showing the patient in the sitting position. From your reviewer's standpoint, this is not modern either. The author particularly refers the reader to special textbooks for detailed information on this subject.

Richardson's course at Tufts may be more thorough and complete than Poe's at Baylor; but Poe has courageously published his. In the absence of handbooks on the subject of anesthesia, the book fills a definite need.

Pathology for Nurses. By EUGENE G. PIETTE, M.D. F. A. Davis Company. Pp. 251. Price $1.75.

This handbook is very useful, giving a bird's-eye view of the field of pathology. Of course with the limited time allotted to this subject in the nurse's curriculum the use of any pathology text is practically out of the question, and this may be regarded as a book from which one of the instructors in the Training School might prepare her lectures.